

**WHITESIDE MIDDLE SCHOOL  
ATHLETIC TEAM TRY-OUT & PARTICIPATION REQUIREMENTS  
2017-2018 School Year**

All students wanting to participate in any sports activity listed below **MUST** have the following turned in to the middle school office by the deadline in order to participate in try-outs. Questions may be directed to Mr. Jacob at 239-0000 x 3605

- Current physical (less than one year old as of tryout date)
- 2017-2018 Sports packet (only one required per school year)
  - Certificate of Physical Fitness for Participation
  - Agreement to Participate
  - Medical Authorization Form
  - Concussion Information Acknowledgement
- Registration fee and all incidental fees (lunch, IDs, library, etc.) paid
- Minimum 2.0 GPA (not applicable for August tryouts)

Students will not be permitted to tryout if any of the above conditions are not met by the deadlines indicated below.

**Early Fall Sports**

Baseball, Softball, Soccer

Tryouts first week of August

Physical, sports packet, and fees due by **Wednesday, July 26**

**Cheerleading**

Tryouts third week of September

Physical, sports packet, and fees due by **Wednesday, September 6**

**Late Fall Sports**

Boys' Basketball (Grades 5-8), Girls Basketball (Grades 5-8)

Tryouts first week in October

Physical, sports packet, and fees due by **Wednesday, September 27**

**Winter Sports**

Boys' Volleyball (Grades 7-8), Girls' Volleyball (Grades 5-8), Bowling

Tryouts first week in January

Physical, sports packet, and fees due by **Wednesday, December 13**

Minimum 2.0 GPA at end of 1<sup>st</sup> semester

**Spring Sports**

Boys' & Girls' Track (Grades 6-8)

Tryouts third week in March

Physical, sports packet, and fees due by **Wednesday, March 7**

Minimum 2.0 cumulative GPA

**Note:** An **Activity Fee** of \$25 for the first activity and \$10 for each additional activity is due two (2) weeks following tryouts or by the first game, whichever comes first.

Students with any outstanding fees on any given Monday will have until Friday of that week to make payment. Students will be required to "sit out" the following week until all fees are paid. If not paid by Friday of the second week, the student will be removed from the team.



# WHITESIDE SCHOOL DISTRICT 115

111 Warrior Way  
Belleville, Illinois 62221

Telephone 618 239-0000  
Middle School Fax 618 239-9240  
Elementary School Fax 618 233-7931

<http://www.wssd115.org>

## Certificate of Physical Fitness for Participation in Athletics – 2017-2018

To be submitted to the Superintendent

Student:	Grade:
Sport or Activity:	

I am the parent(s)/guardian(s) of the above student. I certify that my child/ward is in good physical health and is capable of participation in the above mentioned sport or activity. No need exists to limit his/her participation. I assume full responsibility for his/her physical condition and participation. I will notify you of any changes in his/her physical condition. I have completed and submitted the **Authorization for Medical Treatment** form allowing the school to seek medical treatment for my child in the event of a medical emergency when reasonable attempts to contact me are unsuccessful. If my child requires or may need medication while participating in athletics, I have completed and submitted the **School Medication Authorization Form**.

Parent(s)/Guardian(s) Name:			
Home Address:			
Telephone Number:		Business Phone:	
Child/Ward's Date of Birth:			
Physician's Name:		Telephone Number:	

### Medical History:

	Yes	No		Yes	No
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other		

1. Injuries and/or operations during the past year? (include dates)

\_\_\_\_\_

2. Has your child/ward's physical activity been restricted during the past year? (Reason and Duration)

\_\_\_\_\_

3. Is your child/ward taking any medication?  Yes  No

If yes, why?

Name of medication:

Signature of Parent(s)/Guardian(s);	
Date:	

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**AGREEMENT TO PARTICIPATE**

Each student and his or her parent/guardian must read and sign this *Agreement to Participate* each year before being allowed to participate in interscholastic athletics. The completed *Agreement* should be returned to the middle school office.

Student name (printed) \_\_\_\_\_

1. I wish to participate in the interscholastic athletics during the 2017-2018 school year.
2. I acknowledge reading the eligibility rules as outlined in the student handbook under "Eligibility Standards for Extra-Curricular Activities", coach's rules, and district rules for student conduct, and I agree to abide by them.
3. Before I am allowed to participate, I must: (a) provide the School District with a current certificate of physical fitness and completed sports packet, (b) have a minimum 2.0 GPA, and (c) have no outstanding fees.
4. I agree to abide by all conduct rules and will behave in a sportsmanlike manner. I agree to follow the coaches' instructions, playing techniques, and training schedule as well as all safety rules.
5. I understand that Board policy 7:305, *Student Athlete Concussions and Head Injuries*, requires, among other things, that a student athlete who exhibits signs, symptoms, or behaviors consistent with a concussion or head injury must be removed from practice or competition at that time and that the student will not be allowed to return to play or practice until he or she has successfully completed return-to-play and return-to-learn protocols, including having been cleared to return by the treating physician licensed to practice medicine in all its branches or a certified athletic trainer under the supervision of a physician.
6. I am aware that with participation in sports comes the risk of injury, and I understand that the degree of danger and seriousness of risk vary significantly from one sport to another with contact sports carrying the highest risk. I am aware that participating in sports involves travel with the team. I acknowledge and accept the risks inherent in the sport(s) or athletics in which I will be participating and in all travel involved. I agree to hold the District, its employees, agents, coaches, School Board members, and volunteers harmless from any and all liability, actions, claims, or demands of any kind and nature whatsoever that may arise by or in connection with my participating in the school-sponsored interscholastic sport(s). The terms hereof shall serve as a release and assumption of risk for my heirs, estate, executor, administrator, assignees, and for all members of my family.

Student signature \_\_\_\_\_ Date \_\_\_\_\_

**To be read and signed by the parent/guardian of the student:**

1. I am the parent/guardian of the above named student and give my permission for my child or ward to participate in the interscholastic athletics. I have read the above *Agreement to Participate* and understand its terms.
2. I understand that all sports can involve many **risks of injury**, and I understand that the degree of danger and seriousness of risk vary significantly from one sport to another with contact sports carrying the higher risk. I am aware that participating in sports involves travel with the team. In consideration of the School District permitting my child to participate, I agree to hold the District, its employees, agents, coaches, Board members and volunteers harmless from any and all liability, actions, claims or demands of any kind and nature whatsoever that may arise by or in connection with the participation of my child in the sport(s) or athletics. I assume all responsibility and certify that my child is in good physical health and is capable of participation in the above indicated sport or athletics.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_



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## Medical Authorization Form

To be submitted to the Superintendent

Student:	Grade:		
Sport/Activity:			
Home Address:			
Home Phone:		Birth Date:	

**To whom it may concern:** In the event reasonable attempts to contact me at the locations listed below have been unsuccessful, I, as parent or legal guardian of the above student, do hereby authorize (1) the treatment by a qualified and licensed medical doctor of my child/ward in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed; and (2) the transfer of my child/ward to any hospital reasonably accessible.

This release form is completed and signed of my own free will with the purpose of authorizing medical treatment under emergency circumstances in my absence.

Name and relation to student (please print):			
Address:			
Home Phone:		Business Phone:	
Emergency contact:			
Home Phone:		Business Phone:	
Physician's name:		Physician's Phone:	

*Please list specific medical allergies, medicines, or other conditions on other side of this form.*

Signed :	
Date:	

Whiteside School District #115 maintains Students Accident Insurance coverage on all students while in attendance at school, school-sponsored events and activities, including school athletics. Submission of claims is the responsibility of the parent. This insurance carries a deductible of the greater of \$0 or the amount paid or payable for the same injury by any other plan on which the student is covered.

## Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

<p><b>Symptoms may include one or more of the following:</b></p> <ul style="list-style-type: none"> <li>• Headaches</li> <li>• “Pressure in head”</li> <li>• Nausea or vomiting</li> <li>• Neck pain</li> <li>• Balance problems or dizziness</li> <li>• Blurred, double, or fuzzy vision</li> <li>• Sensitivity to light or noise</li> <li>• Feeling sluggish or slowed down</li> <li>• Feeling foggy or groggy</li> <li>• Drowsiness</li> <li>• Change in sleep patterns</li> </ul>	<ul style="list-style-type: none"> <li>• Amnesia</li> <li>• “Don’t feel right”</li> <li>• Fatigue or low energy</li> <li>• Sadness</li> <li>• Nervousness or anxiety</li> <li>• Irritability</li> <li>• More emotional</li> <li>• Confusion</li> <li>• Concentration or memory problems (forgetting game plays)</li> <li>• Repeating the same question/comment</li> </ul>
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<p><b>Signs observed by teammates, parents and coaches include:</b></p> <ul style="list-style-type: none"> <li>• Appears dazed</li> <li>• Vacant facial expression</li> <li>• Confused about assignment</li> <li>• Forgets plays</li> <li>• Is unsure of game, score, or opponent</li> <li>• Moves clumsily or displays incoordination</li> <li>• Answers questions slowly</li> <li>• Slurred speech</li> <li>• Shows behavior or personality changes</li> <li>• Can’t recall events prior to hit</li> <li>• Can’t recall events after hit</li> <li>• Seizures or convulsions</li> <li>• Any change in typical behavior or personality</li> <li>• Loses consciousness</li> </ul>
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## Concussion Information Sheet

### What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents, and students is the key to student-athlete's safety. The district will follow the graduated return to school protocol developed by the Sports Concussion Institute.

### If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours, IHSA Policy requires athletes to provide their school with written clearance from either a physician licensed to practice medicine in all its branches or a certified athletic trainer working in conjunction with a physician licensed to practice medicine in all its branches prior to returning to play or practice following a concussion or after being removed from an interscholastic contest due to a possible head injury or concussion and not cleared to return to that same contest. In accordance with the state law, all IHSA member schools are required to follow this policy.

You should also inform your child's coach if you think that your child may have a concussion. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:

<http://www.cdc.gov/ConcussionInYouthSports/>

\_\_\_\_\_  
Student-athlete Name Printed

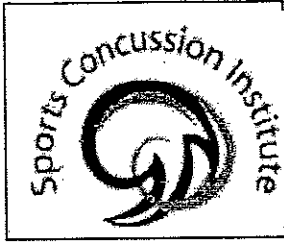
\_\_\_\_\_  
Students-athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian Printed

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date



# Graduated Return to School Protocol

NAME: \_\_\_\_\_

**Recovery Stage 1**

**Complete Physical and Cognitive Rest until Medical Clearance**

- No School Attendance
- Strict Technology Limits
- REST

**Recovery Stage 2**

**Return to School with Academic Accommodations**

- Continue limits on technology use
- Avoid heavy backpacks
- No Tests, PE, Band or Chorus
- Monitor Symptoms
- REST at home

**Recovery Stage 3**

**Continue Academic Accommodations**

- Attend School full time if possible
- Increase work load gradually (testing, homework, etc.)
- Monitor Symptoms
- Incorporate light aerobic activity
- REST at home

**Recovery Stage 4**

**Full Recovery to Academics**

- Attend school full time
- Self-Advocate at school (meet due dates, etc.)
- Resume normal activities
- Return to sports following graduated return to play

Symptom free for 24 hours

YES:  
Begin Stage 2

NO:  
Continue Resting

Symptom free for 24 hours

YES:  
Begin Stage 3

NO:  
Rest until Symptom Free

Symptom free for 24 hours

YES:  
Begin Stage 4

NO:  
Return to Stage 2 until Symptom Free

Symptom free for 24 hours

YES:  
Return to School

NO:  
Return to Stage 3 until Symptom Free

Date Attained:

Date Attained:

Date Attained:

Date Attained:

NOTES:







## State of Illinois Certificate of Child Health Examination

Student's Name			Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
Last	First	Middle	Month/Day/Year			
Address			Parent/Guardian	Telephone # Home	Work	
Street	City	Zip Code				

**IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for every dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.**

REQUIRED Vaccine / Dose	DOSE 1			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT
Polio (Check specific type)	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps, Rubella																		
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

**Comments:**

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature	Title	Date
Signature	Title	Date

**ALTERNATIVE PROOF OF IMMUNITY**

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.  
 \*MEASLES (Rubeola) MO DA YR \*\*MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.  
 Date of Disease Signature Title

3. Laboratory Evidence of Immunity (check one) Measles\* Mumps\*\* Rubella Varicella Attach copy of lab result.  
 \*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.  
 \*\*All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: \_\_\_\_\_  
 Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

