

East St. Louis Senior High School
Athletics Department
2021 – 2022

If you are receiving this packet it is because your or your child have expressed interest in their participation in East St. Louis Senior High School interscholastic athletics in the 2020 – 2021 academic year.

This packet contains necessary **paperwork** that will need to be **completed prior to** you or your child's **participation** in East St. Louis Senior High School interscholastic athletics. In addition to these forms, your child will also need a pre-participation exam (commonly called a physical) completed within the last 365 days.

Please use this page as a checklist to ensure you have completed and signed all appropriate documentation. Forms to be completed and returned include:

- _____ Student-Athlete Authorization and Consent Form
- _____ Student-Athlete Acknowledgement and Assumption of Risk Form
- _____ Consent to Treatment Form
- _____ Illinois High School Association Acknowledgement and Consent Form
(only the last page [page 5] of these forms needs to be returned)
- _____ Pre-Participation Exam (IHSA Health Physical Form)*

Completed paperwork should be submitted to the athletic trainer, Destinee Grove, as early as possible. If you have questions, please feel free to reach Destinee by phone at 618-646-3000 x1036 or by email at destinee.grove@athletico.com.

*Please note that bylaw 2.150 of the Illinois High School Association Handbook prohibits participation in interscholastic sport (including practice) without a physical. Physicals may only be completed by a licensed physician, physician's assistant, or nurse practitioner. You do not have to use the included physical form, though it is provided for convenience.

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East St. Louis Senior High School
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Student-Athlete Authorization and Consent Form

I, _____, the parent/guardian of _____, a student-athlete participating in interscholastic athletics at East St. Louis Senior High School, understand that the disclosure of my student-athlete's protected health information is a condition of participation in East St. Louis Senior High School athletics.

I hereby authorize/consent for physicians and athletic trainers covering East St. Louis Senior High School's athletic events and other healthcare personnel affiliated with East St. Louis Senior High School's athletic programs to release information regarding my student-athlete's protected health information (PHI) and related information regarding any injury or illness which may occur during the student-athlete's training for and participation in athletics at East St. Louis Senior High School to any coach, athletic director, or school official in connected with my student-athlete's participation in interscholastic sports. This protected health information may concern the student-athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable information. This protected information may be released to other healthcare providers, hospitals and/or medical clinics and laboratories, athletic coaches, athletic trainers, medical insurance coordinators, athletic and/or school administrators, and officials of the student-athlete's sport.

I understand that my student-athlete's PHI may be protected by federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) as well as by the Family Educational Rights and Privacy Act (FERPA) and, if so, may not be disclosed without parental/legal guardian's authorization.

I understand, as the parent/guardian of the student-athlete:

This authorization/consent is valid for the duration of this academic year unless I rescind my permission in writing to East St. Louis Senior High School, 4901 State Street, East St. Louis, IL 62205.

A revocation will not affect any uses or disclosures that the school, team physician(s), or athletic trainer(s) made before these parties received my student-athlete's revocation.

If I request it, I may see a copy of the PHI described on this form.

The information that is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. I have the right to seek assurances from the above named entities or individuals authorized to receive the information that they will not re-disclose information to any other party without my further authorization.

I HAVE READ, UNDERSTOOD, AND VOLUNTARILY AGREE TO THE ABOVE STATEMENTS.

Parent/Guardian's Signature

Date

Parent/Guardian's Printed Name

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Student-Athlete Acknowledgement and Assumption of Risk

I, _____, the parent/guardian of _____, and my student-athlete (hereafter referred to as “we”) understand that participation in East St. Louis Senior High School interscholastic sports requires a personal acceptance of risk of injury. Student-athletes generally expect that those who are responsible for the conduct of sport (e.g., coaches) take reasonable precautions to minimize such risk, and that their peers participating in sport will not intentionally inflict wrongful injury upon them.

We understand that participation in interscholastic athletics at East St. Louis Senior High School may result in injury, illness, permanent physical or mental impairment, or even death. These injuries may be minor in nature or may be career, or life, threatening. We understand that East St. Louis Senior High School cannot be held responsible for any injuries or conditions that may be caused by the action of other student-athletes or teams (e.g., opponents). We also understand that injuries may be caused by my or my child’s failure to adhere to safety techniques which are made known to my child by the coaching, athletic training, and strength and conditioning staffs and/or another source, including school medical staff.

We understand there are certain inherent risks involved in participating in interscholastic athletics. We acknowledge the fact that these risks exist and we are willing to assume responsibility for **any and all** such risks while participating in interscholastic athletic events at or sponsored by East St. Louis Senior High School. We also agree to the following:

- A. We voluntarily assume all risk associated with my child’s participation in interscholastic athletics.
- B. We accept that East St. Louis Senior High School and its personnel are not to be held responsible for any pre-existing medical conditions that my child may have.
- C. We understand that having passed the pre-participation physical **does not** necessarily mean that my child is physically qualified to participate in interscholastic athletics at East St. Louis Senior High School but only that the evaluator did not find a medical reason to disqualify me at the time of examination.
- D. We understand that my child must refrain from practice while injured or ill, whether or not my child is receiving medical care. When under medical care, my child may not return to participation until they have been granted permission, based on independent exercise of professional judgement by their attending physician(s) or their designate after review of my child’s condition and fitness for the rigors of my child’s sport(s).
- E. We understand and agree that if my child experiences any injury, illness, or change in health status, **it is my child’s responsibility** to notify and inform the head coach and certified athletic trainer in charge of my sport and to adhere to established injury management guidelines, which includes rehabilitation and reassessment before I am released to return to full participation.

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- F. We understand that my child must wear the proper equipment as directed by the rules of the sport. My child may also have to wear padding and/or brace(s) as indicated by the athletic training staff or medical personnel. Failure to do so may expose my child to increased risk for further injury.

WE HAVE READ, UNDERSTOOD, AND VOLUNTARILY AGREE TO THE ABOVE STATEMENTS.

Student-Athlete's Signature

Date

Student-Athlete's Printed Name

Parent/Guardian's Signature

Date

Parent/Guardian's Printed Name

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Consent to Treatment

I, _____, the parent/guardian of _____, understand that my student-athlete may be injured while participating in East St. Louis Senior High School-sponsored athletics. I hereby grant permission to athletic trainers and physicians covering East St. Louis Senior High School athletic events to evaluate and examine as well as administer any preventative, first aid, or emergency treatments, which they deem reasonably necessary, to the health and well-being of my student-athlete.

I further understand and consent to the athletic trainer's providing advice to my student-athlete concerning nutrition, hydration, and conditioning. The athletic trainer may also provide to my student-athlete hot or cold packs, wound care, taping and/or bracing, massage, whirlpool treatment, soft tissue therapies, and therapeutic exercises to which I also authorize and consent to be performed on my student-athlete during their participation in school-sponsored athletics.

Additionally, I understand that in the case of injury or illness requiring treatment by emergency medical personnel and transportation to a healthcare facility, a reasonable attempt will be made to contact me. However, even if unable to reach me, my child will be treated and transported if necessary.

To facilitate possible treatment and transportation, please provide the following insurance information:

Insurance Information

Insurance Company: _____

Policy Number: _____

Group Number (if applicable): _____

Insurance Company Phone Number: _____

Please check this box **if and only if** your child is uninsured.

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To facilitate timely contact in the event care is provided to your child, please provide the following contact information:

Contact Information

Student-Athlete Name: _____

Date of Birth: _____ Grade Level: _____

Home Address: _____

State/City/Zip Code: _____

Guardian 1 Name: _____ Relationship: _____

Phone Number: _____

Guardian 2 Name: _____ Relationship: _____

Phone Number: _____

Guardian 3 Name: _____ Relationship: _____

Phone Number: _____

This consent form is valid for the duration of the current academic year unless I rescind my permission **in writing** to my student-athlete's school at:

East St. Louis Senior High School
4901 State Street
East St. Louis, IL 62205

I HAVE READ, UNDERSTOOD, AND VOLUNTARILY AGREE TO THE ABOVE STATEMENTS.

Student-Athlete's Signature

Date

Student-Athlete's Printed Name

Parent/Guardian's Signature

Date

Parent/Guardian's Printed Name



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.

Symptoms may include one or more of the following:

<ul style="list-style-type: none"> Headaches “Pressure in head” Nausea or vomiting Neck pain Balance problems or dizziness Blurred, double, or fuzzy vision Sensitivity to light or noise Feeling sluggish or slowed down Feeling foggy or groggy Drowsiness Change in sleep patterns 	<ul style="list-style-type: none"> Amnesia “Don’t feel right” Fatigue or low energy Sadness Nervousness or anxiety Irritability More emotional Confusion Concentration or memory problems (forgetting game plays) Repeating the same question/comment
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Signs observed by teammates, parents and coaches include:

<ul style="list-style-type: none"> Appears dazed Vacant facial expression <ul style="list-style-type: none"> Confused about assignment Forgets plays Is unsure of game, score, or opponent <ul style="list-style-type: none"> Moves clumsily or displays incoordination Answers questions slowly Slurred speech Shows behavior or personality changes <ul style="list-style-type: none"> Can’t recall events prior to hit Can’t recall events after hit Seizures or convulsions Any change in typical behavior or personality Loses consciousness
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Concussion Information Sheet (Cont.)

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.

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. The Youth Sports Concussion Safety Act requires athletes to complete the Return to Play (RTP) protocols for their school 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.

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/>



IHSA Performance-Enhancing Substance Policy

In 2008, the IHSA Board of Directors established the association's Performance-Enhancing Substance (PES) Policy. A full copy of the policy and other related resources can be accessed on the IHSA Sports Medicine website. Additionally, links to the PES Policy and the association's Banned Drug classes are listed below. School administrators are able to access the necessary resources used for policy implementation in the IHSA Schools Center.

As a prerequisite to participation in IHSA athletic activities, we have reviewed the policy agree that I/our student will not use performance-enhancing substances as defined by the policy. We understand that failure to follow the policy could result in penalties being assigned to me/our student either by the my/our student's school or the IHSA.

IHSA PES Policy

<http://www.ihsa.org/documents/sportsMedicine/2017-18/2017-18 PES policy.pdf>

IHSA Banned Drug Classes

<http://www.ihsa.org/documents/sportsMedicine/current/IHSA Banned Drugs.pdf>



IHSA Sports Medicine Acknowledgement & Consent Form

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Acknowledgement and Consent

Student/Parent Consent and Acknowledgements

By signing this form, we acknowledge we have been provided information regarding concussions and the IHSA Performance-Enhancing Substance Policy.

STUDENT

Student Name (Print): _____ Grade (9-12) _____

Student Signature: _____ Date: _____

PARENT or LEGAL GUARDIAN

Name (Print): _____

Signature: _____ Date: _____

Relationship to student: _____

Consent to Self Administer Asthma Medication

Illinois Public Act 098-0795 provides new directions for schools concerning the self-carry and self-administration of asthma medication by students. In order for students to carry and self-administer asthma medication, parents or guardians must provide schools with the following:

Written authorization from a student's parents or guardians to allow the student to self-carry and self-administer the medication.

The prescription label, which must contain the name of the asthma medication, the prescribed dosage, and the time at which or circumstances under which the asthma medication is to be administered.

A full copy of the law can be found at <http://www.ilga.gov/legislation/publicacts/98/PDF/098-0795.pdf>.

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■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

- Medically eligible for all sports without restriction
Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

Medically eligible for certain sports

Not medically eligible pending further evaluation

Not medically eligible for any sports

Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other information: _____

Emergency contacts: _____

Supplemental COVID-19 questions

1. Have you had any of the following symptoms in the past 14 days?
 - a) Fever or chills Yes / No
 - b) Cough Yes / No
 - c) Shortness of breath or difficulty breathing Yes / No
 - d) Fatigue Yes / No
 - e) Muscle or body aches Yes / No
 - f) Headache Yes / No
 - g) New loss of taste or smell Yes / No
 - h) Sore throat Yes / No
 - i) Congestion or runny nose Yes / No
 - j) Nausea or vomiting Yes / No
 - k) Diarrhea Yes / No
 - l) Date symptoms started _____
 - m) Date symptoms resolved _____
2. Have you ever had a positive test for COVID-19? Yes / No
 - If yes:
 - i. Date of test _____
 - ii. Were you tested because you had symptoms? Yes / No
 - If yes:
 - a) Date symptoms started _____
 - b) Date symptoms resolved _____
 - c) Were you hospitalized? Yes / No
 - d) Did you have fever > 100.4 F.? Yes / No
 - If yes, how many days did your fever last? _____
 - e) Did you have muscle aches, chills, or lethargy? Yes / No
 - If yes, how many days did these symptoms last? _____
 - f) Have you had the vaccine? Yes / No
 - iii. Were you tested because you were exposed to someone with COVID-19, but you did not have any symptoms? Yes / No
 3. Has anyone living in your household had any of the following symptoms or tested positive for COVID-19 in the past 14 days? Yes / No
If Yes, circle the applicable symptoms.
 - Fever or chills
 - Muscle or body aches
 - Nausea or vomiting
 - Sore throat
 - Headache
 - Cough
 - Fatigue
 - Diarrhea
 - Shortness of breath or difficulty breathing
 - New loss of taste or smell
 - Congestion or runny nose
 4. Have you been within 6 feet for more than 15 minutes of someone with COVID-19 in the past 14 days? Yes / No
If yes: date(s) of exposure _____
 5. Are you currently waiting on results from a recent COVID test? Yes / No

Sources:

- [Interim Guidance on the Preparticipation Physical Examination... : Clinical Journal of Sport Medicine \(lww.com\)](#)
- [Supplemental COVID-19 Questions \(lww.com\)](#)
- [COVID-19 Interim Guidance: Return to Sports and Physical Activity \(aap.org\)](#)



■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)
Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS		
<i>(Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)</i>		
	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU		
	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU		
<i>(CONTINUED)</i>		
	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		



■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.

- Do you feel stressed out or under a lot of pressure?
• Do you ever feel sad, hopeless, depressed, or anxious?
• Do you feel safe at your home or residence?

During the past 30 days, did you use chewing tobacco, snuff, or dip?

- Do you drink alcohol or use any other drugs?
• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?
• Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of History Form).

Table with columns for EXAMINATION, MEDICAL, MUSCULOSKELETAL, and rows for various physical exam categories like Appearance, Eyes, Heart, Lungs, etc.

ª Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA