PLAYER RECORD PACKET

INTRODUCTION

Each student interested in participating in interscholastic athletics at Chicago Public Schools shall submit a completed Player Record Packet prior to participation in any practice or contest, and before eligibility is established. The Coach/Athletic Director is responsible for securing the packet from the participant and ensuring that it has been completed. The Athletic Director is responsible for recording the information in the sports module in ASPEN, filing paper/electronic records, and making them available to the Department of Sports Administration as needed for auditing purposes.

A completed Player Record Packet includes:

- Completed Player's Record Packet Form including:
  - General Information Form
  - General Parental Consent
  - Equipment Agreement
  - By-Laws Acknowledgment
  - Eligibility Statement

Additional Information that must be submitted for student eligibility:

- Medical Documentation Forms
  - IHSA Pre-participation Examination (within last 395 days)
  - IHSA Sports Medicine Acknowledgement & Consent Form

General Information

School: _____ Name: _____ Student ID: _____ Gender: _____

Date of Birth: _____ Current Age: _____ Address: _____

Emergency Contact Name & Relationship: _____

Emergency Contact Number(s): _____

Date of Enrollment this Semester: _____ Date of Initial Enrollment in High School:_____

Number of Semesters in Attendance in High Schools, Including Present Semester: _____

Sport *(circle all that apply)*:

Baseball Basketball Bowling Cross Country Competitive Cheer/Dance

Football Golf Lacrosse Soccer Softball/16in Swimming/Diving

Tennis Track and Field Volleyball Water Polo Other: _____

Athletic Participation History

School: If other than current school	**Yr.**	Sports Participated:	Injuries & Treatment: ie: Concussions, surgeries, etc.	AAU/Club: Sport/Team Affiliation	Additional Comments
	FR.				
	So.				
	Jr.				
	Sr.				

By-Laws Acknowledgement

I am in receipt of the Chicago Public Schools Athletics constitution and bylaws and agree that my child will abide by all of the Chicago Public League rules.

Student's Initials: _____ Parent/Guardian Initials: _____

Athletic Eligibility

I understand that in order to participate in athletic activities at Chicago Public Schools, including practice and competitions, I must maintain scholastic eligibility. CPS No Pass No Play Policy

Student's Initials: _____ Parent/Guardian Initials: _____

Transportation Acknowledgement

The use of the private vehicles of coaches/school representatives for the purpose of transporting students to athletic events is strongly discouraged. However, when the use of a private vehicle of a coach/school representative is the only feasible method of travel, such vehicles can be allowed if the requirements set by the CPS Student Travel Policy are met. CPS Travel Policy

****Optional****

I grant permission for school personnel to use private vehicles to transport me to athletic events in accordance with the approval and permission of the school Principal based on the conditions and requirements of the CPS Student Travel Policy being met by the agent of transport.

Parent/Guardian Signature: _____

General Consent

Student Name: _____

I represent that I am the parent or legal guardian of the above-named student.

I give permission for my child to participate in high school athletics for SY 2021-2022 (August-July). I understand and acknowledge that there are known and unknown risks and the potential for injury inherent in all athletic activity, including but not limited to: bruises, scrapes, cuts, bumps, fractures, concussions, paralysis, or death.

I acknowledge and understand that participation in sports activities creates additional risks to my child, myself and other members of my family and community associated with potential exposure to illness including the COVID-19 virus and these risks are greater when people are in close contact with each other. I agree to allow my child to participate despite these risks. **I agree that my child will adhere to any safety precautions implemented by staff including but not limited to (1) allowing body temperature checks, (2) answering health-related questions, (3) wearing masks or face-coverings, (4) supplying and using his/her own water bottle(s) and towel(s) and other personal equipment/supplies when engaged in this activity and (5) adhering to social distancing requirements**. I understand that my child's failure to adhere to these requests may disqualify my child from participating in sports activities. I agree that my child will not participate in any athletic activity if my child is positive with, or showing symptoms of, COVID-19.

I, for myself, as well as my child, our heirs, assigns, representatives, and next of kin agree to hold harmless, release, waive any all claims against the Board of Education of the City of Chicago (aka Chicago Public Schools), its officers, employees, and volunteers, from any and all illness, injuries, liabilities or damages arising from participation in sports activities including those arising from negligence or willful and wanton misconduct by the Board of Education of the City of Chicago, its employees, officers and/or volunteers. I additionally agree to indemnify and defend the Board of Education of the City of Chicago for any defense cost or expense arising from any and all claims, injuries, liabilities or damages arising from my child's participation.

Parent/Guardian Signature: _____ Date: _____

Authorization for Medical Treatment and Medical Information/Documents

I understand that in the case of an injury or illness which requires treatment by medical personnel and transportation to a health care facility, a reasonable attempt will be made to contact the student-athlete's parent/guardian. However, if necessary, the student-athlete will be treated and transported via ambulance to a medical facility such as a hospital.

Parent/Guardian Signature: _____ Date: _____

Insurance Information **Optional**

Student Name: _____ Insurance Company: _____

Policy Holder Name: _____ Relationship to Student: _____

Policy Number: _____ Group:_____

Physician Name: _____ Physician Contact Number: _____

Students are not permitted to participate in athletic activities at Chicago Public Schools until they receive medical clearance from a physician and acknowledge that they are aware of the medical risks associated with athletic activities. **Accordingly, parents/guardians must read, complete, and return to the Coach/Athletic Director the following forms fully executed before students are permitted to participate in athletic activity with Chicago Public Schools:**

Media Acknowledgement

Please note that Chicago Public Schools (CPS) sporting events may be live streamed, photographed and recorded.

Your child's entry, presence, and participation at the event constitutes your consent to the live streaming, photographing and recording by CPS and to the release, publication, exhibition, or reproduction of any and all recordings of your child or their voice for any purpose whatsoever in connection with CPS and its initiatives. As an example, this includes use on websites, in social media, or by third-party publications.

By your child attending and participating in the event, you waive and release any claims you may have related to the use of live streaming, photographing and recording of your child at the event, including, without limitation, any right to inspect or approve any photo or recording of your child; any claims of invasion of privacy, violation of the right of publicity, defamation, and copyright infringement; or for any fees for the use of such recorded media.

Parent/Guardian Signature: _____

State of Illinois
Certificate of Child Health Examination

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

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

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.

Last	First	Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	Yes No	List:	**MEDICATION** (Prescribed or taken on a regular basis.)	Yes No	**List:**

Diagnosis of asthma?	Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during night coughing?	Yes	No					
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature**			**Date**
Bone/Joint problem/injury/scoliosis?	Yes	No					

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **BMI PERCENTILE** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed ☐** **Skin Test: Date Read** **Result: Positive ☐ Negative ☐** **mm_____**

Blood Test: Date Reported **Result: Positive ☐ Negative ☐** **Value**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		
NEEDS/MODIFICATIONS required in the school setting			**DIETARY** Needs/Restrictions		

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Modified ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

IHSA Sports Medicine Acknowledgement & Consent Form

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:

- 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
- 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

Signs observed by teammates, parents and coaches include:

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily or displays incoordination
- Answers questions slowly
- Slurred speech
- Shows behavior or personality changes
- 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

IHSA Sports Medicine Acknowledgement & Consent Form

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/

Adapted from the CDC and the 3rd International Conference on Concussion in Sport Document created 7/1/2011 Reviewed 4/24/2013, 7/16/2015, July 2017

IHSA Sports Medicine Acknowledgement & Consent Form

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.

Each year IHSA member schools are required to keep a signed Acknowledgement and Consent form and a current Pre-participation Physical Examination on file for all student athletes.