WHITESIDE MIDDLE SCHOOL
ATHLETIC TEAM TRY-OUT & PARTICIPATION REQUIREMENTS
2015-2016 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)
- 2015-2016 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. The middle school office closes at 4:00pm.

Early Fall Sports
Baseball, Softball, Soccer, *Cheerleading
Tryouts first week of August
*Cheerleading tryouts last week in August
Physical, sports packet, and fees due by **Wednesday, July 29**

Late Fall Sports
Boys' Basketball (Grades 5-8), Girls' Volleyball (Grades 5-8)
Tryouts first week in October
Physical, sports packet, and fees due by **Wednesday, September 23**
Minimum 2.0 current GPA

Winter Sports
Boys' Volleyball (Grades 7-8), Girls' Basketball (Grades 5-8), Bowling
Tryouts first week in January
Physical, sports packet, and fees due by **Wednesday, December 16**
Minimum 2.0 GPA at end of 1st semester

Spring Sports
Boys' & Girls' Track (Grades 6-8)
Tryouts second week in March
Physical, sports packet, and fees due by **Wednesday, March 9**
Minimum 2.0 cumulative GPA

Note: An **Activity Fee** of $25 for first activity and $10 for each additional activity is due 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 MIDDLE SCHOOL
SPORTS INFORMATION

Soccer (Co-Ed)	Cheerleading	Basketball (Girls)	Track
Softball (Girls)	Basketball (Boys)	Volleyball (Boys)	
Baseball (Boys)	Volleyball (Girls)	Bowling	

Note: Softball, Baseball, and Soccer tryouts begin in August before the start of school.

All required information as listed on the front page of this packet must be on file with the school office by the required deadline date. All fees must be current as of deadline and student must have a minimum GPA of 2.0.

Additional Information:

- Registration fees must be paid in full at time of requirement deadline.
- **Activity Fee** of $25 for first activity and $10 for each additional activity is due 2 weeks following tryouts or by the first game, whichever comes first.
- Any outstanding fees indicated on Mondays must be paid by Friday of that week or the student must "sit out" the following week until fees are paid. If fees are not paid by the second Friday, the student shall be removed from the team.
- Students must maintain a minimum 2.0 GPA during the season.
- Parents are NOT to attend tryout sessions.
- Practice schedules will be provided by coaches after tryouts.
- Each participant is expected to attend all practices and to be present at all games.
- During the school year, students must be in attendance during the school day in order to participate in any extra-curricular activity that day.
- After-school detentions will not be rescheduled to accommodate practice/game schedules.
- Students who receive an out-of-school suspension during the season will be removed from the team.
- Students who receive two out-of-school suspensions at any time during the school year will not be eligible to participate in any sport for the remainder of the school year.
- Transportation will be provided **TO** away games/meets with starting times of 6:00pm or earlier on weekdays. Transportation after games is the parent's responsibility. The school **will not** provide bus transportation back to Whiteside after away games/meets.
- Watch the monthly calendar in "Smoke Signals" for game or meet schedules.
- There is a mandatory parent meeting prior to the season for parents of cheerleading, basketball and volleyball team members.

WHITESIDE SCHOOL DISTRICT #115

Certificate of Physical Fitness for Participation in Athletics
2015-2016

Student: _____ Birthdate: _____ Grade: _____

Sports/Activities: _____

I am the parent/guardian of the above named student. I certify that my child/ward is in good physical health and is capable of participation in the above mentioned sports or activities. 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.

Parent/Guardian Name (print) _____

Parent/Guardian Signature: _____ Date: _____

Address: _____

Home phone: _____ Cell/work phone: _____

Physician's Name: _____ Physician's phone: _____

Medical History. Please indicate the following:

	Yes	No		Yes	No
Heart Condition	☐	☐	Epilepsy	☐	☐
Allergies	☐	☐	Asthma	☐	☐
Diabetes	☐	☐	Other _____		

List any injuries and/or operations during the past year and include dates:

_____

Reason and duration for any physical activity restrictions during the past year:

_____

List any medications student is currently taking and reason for each medication:

_____

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.whiteside.stclair.k12.il.us

Agreement to Participate

To be completed by the student-participant and submitted to the Superintendent

Student: _____

Sport or Activity: _____

In consideration of the Whiteside School District 115 permitting me to participate in the above sport or activity, I agree as follows:

1. I will abide by all conduct rules and will behave in a sportsmanlike manner.
2. I will follow the coach/sponsor's instructions, playing techniques, training schedule and safety rules for the above sport or activity.
3. I acknowledge that I am aware that participation in the above sport or activity may involve **many risks of injury**. A serious injury may result in physical impairment or even death. I hereby assume all the risks associated with participation and agree to hold Whiteside School District 115, its employees, agents, coaches, School Board members, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of any kind and nature whatsoever which may arise by or in connection with my participation in the above activity or sport. 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 Completed By The Parent/Guardian:

I, _____ am the parent(s)/guardian(s) of the above named student. I have read the above Agreement to Participate and understand its terms. I understand that all sports can involve many **RISKS OF INJURY**. In consideration of the School District permitting my child/ward to participate in the above sport or activity, I agree to hold Whiteside School District 115, its employees, agents, coaches, School Board members and volunteers harmless from any and all liability, actions, causes of action, debts, claims or demands of any kind and nature whatsoever which may arise by or in connection with the participation of my child/ward in the above sport or activity. I understand and accept the selection process and the expectations as set forth by the coach of this activity. I will provide transportation to and from practices and scheduled events when needed. I assume all responsibility and certify that my child is in good physical health and is capable of participation in the above mentioned sport/activity.

Signature of Parent(s)/Guardian(s): _____

Date: _____

Whiteside's mission is to help all learners reach their maximum potential so that they may become tomorrow's leaders.

WHITESIDE SCHOOL DISTRICT #115

Medical Authorization Form

Student: _____ Grade: _____

Sports/Activities: _____

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.

Parent/Guardian Name (print) _____

Parent/Guardian Signature: _____ Date: _____

Address: _____

Home phone: _____ Cell/work phone: _____

Emergency Contact Name: _____

Home phone: _____ Cell/work phone: _____

Physician's Name: _____ Physician's phone: _____

Please list specific medical allergies, medicines, or other health conditions:

_____

_____

_____

Whiteside School District #115 maintains Student 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

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. 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 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	Student-athlete Signature	Date

Parent or Legal Guardian Printed	Parent or Legal Guardian Signature	Date

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 7/1/2011

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

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 7/1/2011

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 2/2013

DCFS

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. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	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						
Hepatitis B (HB)						
Varicella (Chickenpox)						
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	Measles	Rubella	Mumps			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

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 is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying 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 Date

3. Laboratory confirmation (check one) ☐Measles ☐Mumps ☐Rubella ☐Hepatitis B ☐Varicella
Lab Results Date MO DA YR (Attach copy of lab result)

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

																				Codes:
Date																				
Age/ Grade																				
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
Vision																				
Hearing																				

P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

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)				MEDICATION (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma? Child wakes during night coughing?	Yes No Yes No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	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 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. 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			Gastrointestinal		
Eyes		Amblyopia Yes☐ No☐	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 ☐ Limited ☐

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

Address Phone

(Complete Both Sides)