MARQUETTE ACADEMY

Early Education & Elementary Campus
1110 LaSalle Street
815/433-1199

High School Campus
1000 Paul St.
815/433-0125

Student Information:

1. Child's Name: _____
   Last First Middle
   Birth Date: _____ Male: _____ Female: _____

   Grade Entering: _____
   Race or Ethnicity: (Am Indian/Alaskan Native ☐) (Hispanic ☐) (Asian ☐)
   (White/ Non-Hispanic ☐) (African-Am/Non-Hisp ☐) (Other _____)
   Child's Social Security Number (HS Only):_____-____-_____

2. Child's Name: _____
   Last First Middle
   Birth Date: _____ Male: _____ Female: _____

   Grade Entering: _____
   Race or Ethnicity: (Am Indian/Alaskan Native ☐) (Hispanic ☐) (Asian ☐)
   (White/ Non-Hispanic ☐) (African-Am/Non-Hisp ☐) (Other _____)
   Child's Social Security Number (HS Only):_____-____-_____

3. Child's Name: _____
   Last First Middle
   Birth Date: _____ Male: _____ Female: _____

   Grade Entering: _____
   Race or Ethnicity: (Am Indian/Alaskan Native ☐) (Hispanic ☐) (Asian ☐)
   (White/ Non-Hispanic ☐) (African-Am/Non-Hisp ☐) (Other _____)
   Child's Social Security Number (HS Only):_____-____-_____

School District in which you reside: _____

School transferring in from: _____

Parish or Church you attend: _____

Parent Information:

Lives with (Circle One): Mother Father Both

Primary Guardian: _____
Address: _____
City: _____ Zip: _____
Employment: _____
Occupation: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
E-Mail: _____

Secondary Guardian: _____
Address: _____
City: _____ Zip: _____
Employment: _____
Occupation: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
E-Mail: _____

Student(s) Name(s): _____

HANDBOOK AGREEMENT

We have read and understand the contents of the parent/student handbook and agree to abide by the rules and expectations stated therein.

_____
Student(s) Signature Date

_____
Parent(s)/Guardian(s) Signature Date

PARENT PERMISSION FORM FOR INTERNET ACCESS

Marquette Academy believes that the benefit to students from access to the Internet in the form of information resources and opportunities for collaboration far exceed the disadvantages of access. Should a parent prefer that a student not have Internet access, use of the computers is still possible for more traditional purposes such as word processing.

Terms and Conditions of Internet Agreement

I have read the Marquette Academy Internet policy that is found in the handbook and will review this policy with my child(ren).

I understand that the school does not have control of the Internet content, and I realize that students may be accidentally exposed to material that is controversial or offensive while partaking in an educational lesson.

I release Marquette Academy from any liability or damages that may result from my child's inappropriate or unauthorized use of the Internet.

I release Marquette Academy from any liability related to consequences resulting from my child's unauthorized use of the Internet.

Having carefully read the school's Internet policy, I give permission for my child(ren) to have Internet access at the school. I will support the school's Acceptable Use Policy and reinforce it with my child(ren).

_____
Parent(s)/Guardian(s) Signature Date

PUBLICITY FORM

On occasion, Marquette Academy takes photographs or makes an audio or video tape recording of children and/or adults involved in school/parish activities. Such photographs or video records may be used by staff and participants to remember the activities or participants. In addition, such photographs and audio/visual recordings may be used in publications or advertising materials to let others know about our school/parish. In addition, local news organizations may hear of our activities or events, and our school/parish may invite or allow them to photograph or record our events to be used, distributed, or displayed as agents of the school/parish see fit. This consent includes but is not limited to: photographs, videotape, and audio recordings.

_____
Parent(s)/Guardian(s) Signature Date

SERVICE PROJECT (GRADE 8)

I hereby agree that my child _____ may help in the school cafeteria during lunch hour when needed.

_____
Parent(s)/Guardian(s) Signature Date

Marquette Academy
PERMISSION FORM FOR SCHOOL WALKING TRIPS

I am the custodial and responsible parent/guardian of _____
Name of Student(s)

I request that Marquette Academy allow my school aged child(ren) to participate in walks to various locations around the Marquette Academy Early Education campus neighborhood. The Marquette Academy teachers and students will take walks to learn about what is currently being studied in class, such as the signs of changes in the seasons and traffic signs.

I request that Marquette Academy allow my preschool, elementary and/or high school aged child(ren) to participate in walks between the Marquette Academy campuses for Masses, plays, retreats, etc. I also request that M.A. allow my student to participate in walks to WCMY Radio Station, 216 Lafayette Street and to area parks.

The activity will be supervised by at least one school employee.

If my child is injured in any way during this trip and if I cannot be immediately contacted at the following phone number _____, I grant full power to the supervising school employee to do as follows:

1. Arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and

2. Sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

I understand the risks such trips present to my child, including, but not limited to, serious personal injury or death. Any questions I have concerning these trips have been answered.

In consideration for my child being allowed to make any walking trip, I hereby RELEASE AND AGREE TO INDEMNIFY AND HOLD HARMLESS the Diocese, the parish, the school and their employees and agents, and the volunteers assisting the school, from any and all liability for injuries, damages, medical expenses, or any other loss to my child or family or me (including attorney's fees) arising from or related to my child's participation in an activity.

_____	_____
Signature of Parent/Guardian	Signature of Parent/Guardian
_____	_____
Printed name of Parent/Guardian	Printed name of Parent/Guardian
_____	_____
Date	Date

Need 1 Per Student

catholic schools
Diocese of Peoria

CATHOLIC DIOCESE OF PEORIA, IL

MEDICAL INFORMATION

STUDENT/MINOR NAME (first, middle, last): _____

Address: _____ Date of Birth: _____

STUDENT/MINOR'S DOCTOR (first, middle, last): _____ Phone: _____

MEDICAL CONDITIONS: Please list any medical conditions of the student/minor (asthma, diabetes, epilepsy, etc.):

_____

_____

List any allergies or allergic reactions to medications of the student minor: _____

_____

List any medications the student/minor is presently taking: _____

_____

Other pertinent medical information: _____

Date of student/minor's most recent tetanus shot: _____

MEDICAL INSURANCE INFORMATION: Insurance Company: _____

Plan Number: _____ Employee Identification#: _____

EMERGENCY CONTACTS: Parent or Guardian (first, middle, last name): _____

Cell: _____ Work: _____ Home: _____

Other Contact: Name (first, middle, last): _____

Phone (with area code): _____ Relationship to student/minor: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

This information will be kept in the possession of the school/parish. A copy will be distributed to the person in charge of each trip or athletic activity in which the student/minor participates. Should the need arise this information will be given to the proper medical authorities.

I, _____, [parent/guardian], understand that in the case of illness or injury to my child, _____[child's name], the school/parish will try to notify me or the person I have listed as an emergency contact. In case of medical emergency concerning my child, at a time when I or my listed emergency contact cannot be notified, I grant full power to the school/parish to 1) arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited tom, an emergency room of a hospital, a doctor's office, or a medical clinic; and 2) sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

Signature of Parent/Guardian: _____ Date: _____

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						
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
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.

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

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. 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

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last	First	Middle		Birth Date: (Month/Day/Year) / /
Address: Street	City	ZIP Code		Telephone:
Name of School:			Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:			Address (of parent/guardian):	

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note _____

Signature of Dentist _____ Date of Exam _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

IOCI 0600-10

Printed by Authority of the State of Illinois

Marquette Academy Grade School - Athletic and Sporting Events
Parental/Guardian Consent Form and Liability Waiver

Student's Name: _____

Birth Date: _____ Gender: _____

Parent/Guardian's Name: _____

Home Address: _____

Home Phone: _____ Work #: _____ Cell #'s: _____

Request for Permission:
As parent and/or legal guardian, I give permission for my son/daughter named above to participate in interscholastic athletics in the following sports during the current academic year:

___ Baseball	___ Basketball	___ Scholastic Bowl
___ Softball	___ Cross Country	
___ Volleyball	___ Cheerleading	

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant").

I am aware that participating in sports will involve travel to practices and games. I acknowledge and accept the risks involved with my child's travel. I further understand that participation in sports presents to my child the risk of harm, including, but not limited to, serious personal injury or death. Any questions I have concerning my child's participation have been answered.

In consideration of my child being allowed to participate in the sport(s) indicated above, I hereby RELEASE AND AGREE TO INDEMNIFY AND HOLD HARMLESS the Catholic Diocese of Peoria, the parishes, the school, coaches, chaperones, volunteers or representatives associated with the event, and their employees and agents, from any and all liability for injuries, damages, medical expenses, or any other loss to my child or family or me (including attorneys' fees) arising from or related to my child's participation. Additionally, I give my consent and approval for my child's name and picture to be printed in any sports program, publication or video.

As a parent/guardian, I further acknowledge that I am a role model. I will remember that school athletics is an extension of the classroom, offering important learning experiences for the students. Therefore, I will show respect for all players, coaches, spectators, and officials. I will only participate in cheers that support, encourage and uplift the teams involved. I understand the spirit of fair play and good sportsmanship expected by a Catholic school, and accept the responsibility that comes with being a parent/guardian of a student athlete.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

IESA Protocol for Implementation of NFHS Sports Playing Rule for Concussions

2017

"Any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion (such as loss of consciousness, headache, dizziness, confusion, or balance problems) shall be immediately removed from the contest and shall not return to play until cleared by an appropriate health care professional."

The above language which first appeared in all National Federation sports rule books for 2010-11 school term, reflects a strengthening of rules regarding the safety of athletes suspected of having a concussion, but not a revision in primary responsibilities in these areas. Previous rules required officials to remove any athlete from play who was "unconscious or apparently unconscious." This revised language reflects an increasing focus on safety, given that the vast majority of concussions do not involve a loss of consciousness. However, the revised language does not create a duty that officials are expected to perform a medical diagnosis. The change in rule simply calls for officials to be cognizant of athletes who display signs, symptoms or behaviors of a concussion from the lists below and remove them from play.

Definition of a Concussion
A concussion is a traumatic brain injury that interferes with normal brain function. An athlete does not have to lose consciousness (be "knocked out") to have suffered a concussion.

Behavior or signs observed indicative of a possible concussion	Symptoms reported by a player indicative of a possible concussion
• Loss of consciousness	• Headache
• Appears dazed or stunned	• Nausea
• Appears confused	• Balance problems or dizziness
• Forgets plays	• Double or fuzzy vision
• Unsure of game, score, or opponent	• Sensitivity to light or noise
• Moves clumsily	• Feeling sluggish
• Answers questions slowly	• Feeling foggy or groggy
• Shows behavior or personality changes	• Concentration or memory problems
• Can't recall events prior to or after the injury	• Confusion

NOTE: The persons who should be alert for such signs, symptoms, or behaviors consistent with a concussion in an athlete include appropriate health-care professionals, coaches, officials, parents, teammates, and, if conscious, the athlete him/herself.

Protocol

Background: This protocol is intended to provide the mechanics to follow during the course of contests/matches/events when an athlete sustains an apparent concussion. For the purposes of this policy, appropriate health care professionals are defined as: physicians licensed to practice medicine in all its branches in Illinois and certified athletic trainers.

Policy:
1. During the pre-game conference of coaches and officials, the official shall remind the head coaches that a school-approved appropriate health care professional (who meets the description above) will need to clear for return to play any athlete removed from a contest for an apparent head injury.

2. The officials will have no role in determining concussion other than the obvious situation where a player is unconscious or apparently unconscious as is provided for under the previous rule. Officials will merely point out to a coach that a player is apparently injured and advise the coach that the player should be examined by the school-approved health care provider.

3. If it is confirmed by the school's approved health care professional that the student did not sustain a concussion, the head coach may so advise the officials during an appropriate stoppage of play and the athlete may re-enter competition pursuant to the contest rules.

4. **Otherwise,** if an athlete can not be cleared to return to play by a school-approved health care professional as defined in this protocol, that athlete may not be returned to competition that day and is then subject to his or her school's Return to Play Protocols before the student-athlete can return to practice or competition.

5. Following the contest, a Concussion Special Report must be filed by the contest official(s) with the IESA Office through the Officials Center.

6. In cases where an assigned IESA state finals event medical professional is present, his/her decision to not allow an athlete to return to competition may not be over-ruled.

Additional information regarding concussions can be accessed on the IESA website: www.iesa.org/concussion

IESA Protocol for Implementation of NFHS Sports Playing Rule for Concussions

Return to Play (RTP) Policy

Background: With the start of the 2010-11 school term, the National Federation of State High School Associations (NFHS) implemented a new national playing rule regarding potential head injuries. The rule requires "any player who exhibits signs, symptoms, or behaviors consistent with a concussion (such as loss of consciousness, headache, dizziness, confusion, or balance problems) shall be immediately removed from the game and shall not return to play until cleared by an appropriate health care professional." In applying that rule in Illinois, it has been determined that only certified athletic trainers and physicians licensed to practice medicine in all its branches in Illinois can clear an athlete to return to play the day of a contest in which the athlete has been removed from the contest for a possible head injury.

In 2015, the Illinois General Assembly passed the Youth Sports Concussion Safety Act, and this legislation, among other items, required schools to develop Concussion Oversight Teams and create Return to Play (RTP) and Return to Learn (RTL) protocols that student-athletes must meet prior to their full return to athletic or classroom activity.

Mandatory Concussion Course for Coaches

Required concussion education for all athletic coaches and marching band directors is another component of the Youth Sports Concussion Safety Act passed by the Illinois General Assembly in the fall of 2015.

The IHSA/IESA program includes two video presentations and other supplementary materials that ALL interscholastic athletic coaches, marching band directors, and Concussion Oversight Team members need to review prior to taking a required exam over the curriculum. Individuals will be required to demonstrate proficiency on the exam by scoring at least 80% in order to serve as an athletic coach or marching band director at an IESA member school.

The program offers training in the subject matter of concussions, including evaluation, prevention, symptoms, risks, and longterm effects. Coaches will be able to access the program after logging into the IESA Schools Center and clicking on the Concussion Certification link, which will be located above your school's activity tracker.

For more information on the Youth Sports Concussion Safety Act, including specific requirements of the law and other concussion education providers besides IHSA or IESA, individuals can access resources:

On the IHSA website at http://www.ihsa.org/Resources/SportsMedicine.aspx
On the IESA website at http://www.iesa.org/activities/concussion.asp

For those first adopters of this training, new curriculum from the IHSA/IESA is expected to be released in March of 2018 so those whose training will expire in 2018 will be able to remain in compliance with the law.

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 in coordination
- 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, Reviewed 4/24/2013, 7/2015, 7/2017, 6/2018

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. The Return-to-Play Policy of the IESA and IHSA 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 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/Parent Consent and Acknowledgements
By signing this form, we acknowledge we have been provided information regarding concussions.

Student

Student Name (Print): _____ Grade: _____

Student Signature: _____ Date: _____

Parent or Legal Guardian

Name (Print): _____

Signature: _____ Date: _____

Relationship to Student: _____

Each year IESA 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.

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 7/1/2011, Reviewed 4/24/2013, 7/2015, 7/2017, 6/2018

IHSA IESA

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. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

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: _____

_____

_____

TURN IN TO SCHOOL

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 (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	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 (*CONTINUED*)	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).

EXAMINATION		
Height:	Weight:	
BP: / (/) Pulse:	Vision: R 20/ L 20/	Corrected: ☐ Y ☐ N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[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

Keep for Personal Records

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

Keep for Personal Records

Consent Form to Self Administer Asthma Medication

(not needed if current form is already on file with school)

Parent Consent

I, _____, do hereby give my son/daughter, _____,
Permission to self-administer his/her asthma medication as prescribed by his/her physician during athletic competition.

_____ _____
Signature of Parent or Guardian Date

Physician Consent

As a patient under my care, _____, is prescribed to self-administer the following asthma medication.

Medication _____

Purpose _____

Dosage _____

Time/Special Circumstances _____

_____

_____ _____
Signature of Physician Date

MARQUETTE ACADEMY · 2020/2021 SPECIAL EVENTS

PARENT VOLUNTEER FORM

The purpose of our Special Fundraising Events is to raise money to help offset the cost of tuition for every student who attends Marquette Academy. We need your help to be successful. Contact Julie Verona, Advancement Director, at 815-433-0125 Ext 1017 or jverona@marquetteacademy.net with any questions. Hours worked can also be applied toward financial aid hours.

We ask every family to find THREE ways to help. Whether it's attending the events, a donation or volunteering, your participation is necessary. If you need more information on job duties please email jverona@marquetteacademy.net. Simply fill out this form and return to MA in your registration packets, attn: Special Events, or email jverona@marquetteacademy.net. We look forward to working with you!

PARENT INFORMATION

Mother's Name _____ Email_____ Phone_____

Father's Name_____ Email_____ Phone_____

Child's name and grade level_____

SPECIAL EVENTS THAT YOU WON'T WANT TO MISS

Alumni & Family Weekend

_____ Purchase a Raffle Ticket _____Help Sell Raffle Tickets _____Purchase a tailgate ticket at $25

I am willing to volunteer and help with one of the following time slots:

_____ Setup 1-3pm

_____ Food Server 3:30-6:30pm

_____Runner/Garbage Duty 4-7pm

_____ Cleanup 7-8pm

I am willing to donate the following item(s):

_____Yes, I can donate 2 cases of Beer

_____Yes, I can donate 4 cases of Water

_____Yes, I can donate 2 cases of Soda

_____Yes, I can donate paper products

Merry Everything Food Tasting and Christmas Bazaar

_____ Help sell Raffle Tickets

_____ Buy Raffle Tickets

_____ Yes, I can donate Baked Goods

_____Yes, I can donate 2 cases of Beer

_____Yes, I can donate 4 cases of Water

_____Yes, I can donate Wine

I am willing to volunteer and help with one of the following time slots:

_____ Setup 3-8pm (date to be determined)

_____ Work the Baked Goods Table 4-6pm, or 6-8pm

_____ Garbage Duty 4-7pm, or 7-10pm

_____ Food Servers 4:30-8pm

_____ Cleanup 8-10pm (need many)

May Merriment

Be a part of the biggest fundraiser of the year. The money that we raise directly benefits our students and the school! It takes many volunteers and supporters to make this event possible. We hope you will be a part of it!

_____ Purchase a Big Cash Raffle Ticket for $100

_____ Purchase a Tuition Raffle Ticket for $100

_____ Help sell Raffle Tickets

Acquisitions

_____ Yes, I have airline miles, hotel stays or a condo that can be sold at the Auction

_____ Yes, I have tickets to concerts or sporting events that can be sold at the Auction

_____ Yes, I have unique one of a kind opportunity that can be sold at the Auction

_____ Yes, I would like to organize a trip to be featured in the Live Auction

Table Captain

_____ Yes, I can be a table Captain to fill a table of 8 guests

Auction Catalog

_____ Description writer

_____ Proofreader

Auction Invitations

_____ Help with stuffing envelopes and mailing invitations

Decorations

_____ Help with decorations for MMM39

Auction Setup

Help set up the gym the last week of April:

_____ Thursday, April 28, 1-7pm, Set up gym, tables and décor

_____ Friday April 30, 9am – 5pm, Set up gym, tables and décor

Donate/Sponsorship

_____ Please contact me, I will donate and item service or gift for the Silent Auction

_____ Please contact me, I would like to become a sponsor for MMM39

_____ Please contact me, I would like to be an underwriter for MMM39

_____ Please contact me, I know a business that would sponsor and/or donate

Auction Night Volunteers – Saturday, May 1, 2021

_____ Supervise student food servers/waitresses 4:30 – 9:30pm

_____ Be a Silent Booth Worker – 4:45 -10pm

_____ Supervise the student presenters 7-10pm

_____ Supervise the student audio/video Team 7-10pm

_____ Supervise Dishwashers and Cleanup Crew 7-10:30pm

_____ Check In and Check Out Representative 4:30-10pm (need 4)

_____ Raffle Tables – 4:45-10pm (need 4-6)

_____ Take Pictures