Marquette Academy

Academic Excellence in a Catholic Community

May 15, 2023

Dear Parents,

We are beginning to prepare for the next school year at Marquette Academy. Enclosed in this packet you will find your registration information and all pertinent documents you will need.

We are offering an early registration discount of $100.00 to families from now until 7 pm on June 15. We have several opportunities to drop off your completed packets and benefit from the early registration discount. The schedule of dates, etc. is listed below.

Let us know if you have any questions when you review your packet. **Once you complete your packet, you can send it in your student's backpack or return it to the grade school office any time before school is done. Please be sure to include the minimum $400.00 registration fee. You will receive additional financial information via email from Mary Roberson.**

Below are the drop off dates/times for registration:

ALL COMPLETED PACKET DROP OFFS ARE AT THE **GRADE SCHOOL CAMPUS**:

Wednesday, 5/31 from 5-7 pm grade school office

Starting 6/6 every Tuesday/Thursday during summer between the hours of 8 am - 4 pm. at the **Grade School office**

Thursday, 6/15 from 5 - 7 pm grade school office—**last day for the $100 early discount**

In order to receive the **$100 early bird registration discount**--you must have all paperwork and registration fees (minimum $400.00) turned in by **Thursday, 6/15.**

Wednesday, 7/19 from 5 - 7 pm at the grade school office-- **Final registration** drop off

Any registration received after 7/19 will include a $250.00 late fee.

Thank you very much for your patience and cooperation. If you do not need this information, please pass it on to someone who might or return it to us.

Respectfully yours,

Brooke Rick
Principal
Marquette Academy

Parents,

All attached financial sheets need to be signed and returned with your packet.

Any changes to your financial sheet (early discount, scholarships, etc.) will be added later and sent to you via email by Mary Roberson.

Thank you.

MARQUETTE ACADEMY

Academic Excellence in a Catholic Community

Brooke Rick
Principal

Fr. Austin Bosse
Chaplain

Todd Glade
Dean of Students

Lisa Tenut
Business Manager

RE: New for the 23 24 School Year

Marquette Academy Blue/Gold Hours

Dear MA families,

For the upcoming school year we are implementing a new program called Blue/Gold hours. Each MA family will be required to work a minimum 5 hours of service to the school. These hours will be mandatory for each MA family. Please note—Financial Aid hours are over and above the required 5 Blue/Gold hours. The first 5 hours completed by each family will be logged as your Blue/Gold hours.

Some examples would be (but not limited to) help at May Merriment for set up, clean up or working the event; working the annual pork chop dinner, working the annual fish dinner, helping with cleaning at the school, etc.

We will send out emails from the offices when there is a need for help and then we can log hours as they are worked. You can work 1 hour for an event or do 5 hours for one event, whatever is easiest for you and your family.

Please let us know if you have any questions.

Thank you in advance for your cooperation in this matter.

Sincerely,
Mrs. Brooke Rick

Parent Signature: _____
(By signing above you are confirming that you are aware of the new mandatory program)

Please print family name: _____

Parents,

This is for your records

Please use the attached sheet to set up your FACTS payment plan for tuition. If you already have an account, your information will follow from year to year.

Thank you.

MARQUETTE ACADEMY

Academic Excellence in a Catholic Community

Welcome to Marquette Academy. ALL PAYMENTS ARE REQUIRED TO BE ACH PAYMENTS THROUGH FACTS ONLY. THE INVOICE OPTION IS NO LONGER AVAILABLE.

We've listed below how to sign up on Facts but if you have any questions please let us know. Both Mary Roberson and Lisa Tenut can help you. They both work at the High School campus and work with all Marquette families. Once we see that you have signed up on the Facts web site your name will be in a pending file and we will finalize it. You can then start paying. Your monthly payments will not start until August or later if coming to Marquette at a later date. **But please sign up on this site as soon as possible.**

Starting 2023-24 School Year--If you are an existing MA family and have the "invoice" option on FACTS from previous years, you have to go in to FACTS and update what other payment option you want since invoice is no longer an option.

TO SIGN ON TO THE FACTS MANAGEMENT WEBSITE:

Go to our Marquette Academy website www.marquetteacademy.net at the top of the page is ADMISSIONS click on that and a drop down box will appear. The 7th Item under **Admissions** is FACTS, click that, on the right side of the page it says **HAVE ACCOUNT** or below that is **NEW ACCOUNT** click on new account if you have not signed up on Facts before. Click on **CREATE USSERNAME AND PASSWORD** for a new **account**, enter your email address and press enter: 0

Welcome! Thank you for using FACTS.

Please take a few moments to create a user account.

It is highlighted in green Create a new FACTS account click on that and enter your email, then name, address, phone number then it will guide you through the process.

Here is the FACTS phone number for Customer Service in case you need help: 1/866-441-4637 you can talk to any Customer Service person. FACTS Management Website at: https://online.factsmgt.com.

After you have finished setting up your account, we will see your name in **pending we will finalize it** and then we will enter your balance. After that you should see your account by the next day. **Keep track of your Customer number or ID number for future reference.**

Let Mary Roberson – mroberson@marquetteacademy.net or Lisa Tenut – ltenut@marquetteacademy.net know if you have any questions or need help with signing on.

(If you already have a FACTS account every year it will roll over to the new year so you will have the same ID and Customer number. At the beginning of the year your account will be in pending and after we enter your amounts you will be able to see it. Just make sure to check your (checking/savings/credit card) account # to see if that's the one you want to use again. You can change that at any time on FACTS.

Parents,

All attached registration forms need to be completed and returned.

Thank you.

MARQUETTE ACADEMY

Early Education & Elementary Campus
1110 LaSalle St., Ottawa, IL
815/433-1199

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

Student Information:

1. Child's Name: _____
Last First Middle
Social Security No: (HSOnly): _____ Birth Date: _____

Race or Ethnicity: (Am Indian/Alaskan Native ☐) (Hispanic ☐)
(Asian ☐) (White/ Non-Hisp ☐) (African-Am/Non-Hisp ☐)
Other _____ Male: ☐ / Female: ☐ Grade entering: _____

2. Child's Name: _____
Last First Middle
Social Security No: (HSOnly): _____ Birth Date: _____

Race or Ethnicity: (Am Indian/Alaskan Native ☐) (Hispanic ☐)
(Asian ☐) (White/ Non-Hisp ☐) (African-Am/Non-Hisp ☐)
Other _____ Male: ☐ / Female: ☐ Grade entering: _____

3. Child's Name: _____
Last First Middle
Social Security No: (HSOnly): _____ Birth Date: _____

Race or Ethnicity: (Am Indian/Alaskan Native ☐) (Hispanic ☐)
(Asian ☐) (White/ Non-Hisp ☐) (African-Am/Non-Hisp ☐)
Other _____ Male: ☐ / Female: ☐ Grade entering: _____

4. Child's Name: _____
Last First Middle
Social Security No: (HSOnly): _____ Birth Date: _____

Race or Ethnicity: (Am Indian/Alaskan Native ☐) (Hispanic ☐)
(Asian ☐) (White/ Non-Hisp ☐) (African-Am/Non-Hisp ☐)
Other _____ Male: ☐ / Female: ☐ Grade entering: _____

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: _____

Parish or Church You Attend: _____

School District in which you reside:
_____

School transferring in from:
_____

catholic schools
Diocese of Peoria
FAITH IN OUR FUTURE

MEDICAL INFORMATION
ONE PER STUDENT

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 may 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: _____

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 Preschool/Elementary/High School campuses neighborhoods. 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

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

Parents,

All attached medical exams need to be completed and returned at the start of school.

Thank you.

Dear Parents,

Below are the State medical requirements for the upcoming school year. Please let us know if you have any questions. The appropriate forms for your students are included in the packets and online. All of these forms are **DUE AT THE START OF SCHOOL** with the exception of the dental exam. That can be completed at their first scheduled dental appointment during the school year but has to be turned in by April.

Preschool:
Complete doctor physical with updated immunizations for the first time in preschool.

Kindergarten:
Complete doctor physical with updated immunizations
Complete eye exam
Complete dental examination

Grade 2:
Complete dental examination

Grade 6:
Complete doctor physical with updated immunizations
**IESA sports preparticipation physical evaluation (if playing sports)
Complete dental exam

Grade 5-12:
**Complete IESA/IHSA preparticipation physical evaluation (if playing sports).
Concussion Information Acknowledgement and Consent Form (only parent signature required-if playing sports) IESA form is required for grades 5-8. IHSA form is required for grades 9-12.

Grade 9:
Complete doctor physical with updated immunizations
Complete dental examination
**IHSA sports preparticipation physical evaluation (if playing sports)
Concussion Information Acknowledgement and Consent Form (only parent signature required-if playing sports). IHSA form is required for grades 9-12.

****The IESA/IHSA preparticipation form is new from the State of Illinois. This form needs to be completed and signed by both parents and the physician completing the physical.**

New Student entering from outside Illinois:
Complete doctor physical with updated immunizations
Complete dental examination
Complete eye exam
IESA/IHSA sports preparticipation physical evaluation (if playing sports in grades 5-12)
Concussion Information Acknowledgement and Consent Form (only parent signature required). IESA form is required for grades 5-8 and IHSA form is required for grades 9-12.

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: * indicates invalid dose

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	
Child wakes during night coughing?	Yes	No	
Birth defects?	Yes	No	
Developmental delay?	Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	
Diabetes?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No	
Seizures? What are they like?	Yes	No	
Heart problem/Shortness of breath?	Yes	No	
Heart murmur/High blood pressure?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No	

Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Hospitalizations? When? What for?	Yes	No	
Surgery? (List all.) When? What for?	Yes	No	
Serious injury or illness?	Yes	No	
TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
TB disease (past or present)?	Yes*	No	
Tobacco use (type, frequency)?	Yes	No	
Alcohol/Drug use?	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)

Ear/Hearing problems?	Yes	No	
Bone/Joint problem/injury/scoliosis?	Yes	No	

Dental ☐ Braces ☐ Bridge ☐ Plate Other

Information may be shared with appropriate personnel for health and educational purposes.
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 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

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

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

Student's Race/Ethnicity:

☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown
☐ Other_____

To be completed by dentist:

Date of Most Recent Examination:_____ (Check all services provided at this examination date)

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

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

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date:_____
☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date:_____
☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date:_____

Additional comments:_____

Signature of Dentist _____ License #:_____ Date:_____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

IOCI 0600-10 Printed by Authority of the State of Illinois

GRADES 5 – 8

GRADE SCHOOL ATHLETICS

PLEASE RETURN THESE FORMS SIGNED.

THANK YOU.

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: _____

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 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.

GRADES 5– 8

GRADE SCHOOL ATHLETICS

PLEASE READ AND KEEP THESE FORMS.

THANK YOU.

IESA

IMPLEMENTATION OF NHFS SPORTS PLAYING RULE FOR CONCUSSIONS

The National Federation of State High School Associations (NFHS) institutes a 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 contest and shall not return to play until cleared by an appropriate health care professional."

DEFINITION OF CONCUSSION - A concussion is a traumatic brain injury that interferes with normal brain function. An athlete doesn't have to lose consciousness to have suffered a concussion. *NOTE: The persons who should be alert for such signs, symptoms, or behaviors consistent with a concussion in an athlete include appropriate healthcare professionals, coaches, officials, parents, teammates, and, if conscious, the athlete himself/herself.*

BEHAVIOR OR SIGNS OBSERVED THAT ARE INDICATIVE OF A POSSIBLE CONCUSSION	SYMPTOMS REPORTED BY A PLAYER THAT ARE 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

PROTOCOL

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 will need to clear for return to play any athlete removed from a contest for an apparent head injury, unless that injury is the result of the student-athlete losing consciousness for any period of time. In such a situation, the student-athlete shall be removed from the practice or contest and will not be allowed to return to activity that day and will be subject to the Association's Return to Play policy.

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. <u>RETURN TO PLAY POLICY</u>
   Background: With the start of the 2010-11 school term, the 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 cases when an athlete is not cleared to return to play the same day as he/she is removed from a contest following a possible head injury (i.e., concussion), the athlete shall not return to play or

(continued on next page)

practice until the athlete is evaluated by and receives written clearance from a licensed healthcare provider to return to play. For the purposes of this policy, licensed health care providers consist of physicians licensed to practice medicine in all its branches in Illinois and certified athletic trainers working in conjunction with physicians licensed to practice medicine in all its branches in Illinois.

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 overruled.

MANDATORY CONCUSSION COURSE FOR COACHES

Senate Bill 7 (Public Act 99-245) amends the School Code and will go in to effect for the 2016-2017 school year. The legislation requires ALL interscholastic athletic coaches to take a training course from an authorized provider at least once every 2 years. The IESA makes the IHSA online concussion awareness and education program available to IESA member schools through the IESA Member Center. The program includes information on concussion awareness training, concussion recognition, best practices for avoiding concussions, return to play guidelines, and sub-concussive trauma. The presentation and other supplementary materials included in the presentation should be reviewed by ALL interscholastic athletic coaches prior to taking a required exam over the curriculum.

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