



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,

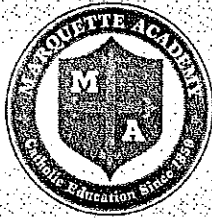
Brooke Rick
Principal
Marquette Academy

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

RE: New for the 23 24 School Year

Marquette Academy Blue/Gold Hours

Brooke Rick
Principal

Fr. Austin Bosse
Chaplain

Todd Glade
Dean of Students

Lisa Tenut
Business Manager

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: _____

Preschool & Elementary Campus
1110 LaSalle St., Ottawa, IL 61350
815.433.1199



High School Campus
1000 Paul St., Ottawa, IL 61350
815.433.0125

www.marquetteacademy.net

Traditions are embraced. Dedication is the norm. Excellence is the expectation.

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 USERNAME 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 – ltanut@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.

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

MARQUETTE ACADEMY

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

Student Information:

1. Child's Name: _____

Social Security No: (HSOnly): _____ Last First Middle 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: _____

Social Security No: (HSOnly): _____ Last First Middle 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: _____

Social Security No: (HSOnly): _____ Last First Middle 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: _____

Social Security No: (HSOnly): _____ Last First Middle 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: _____

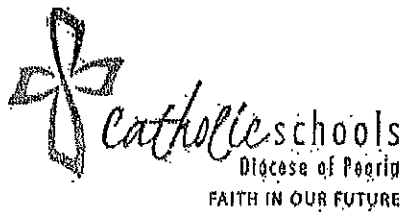
Work Phone: _____

E-Mail: _____

Parish or Church You Attend: _____

School District in which you reside: _____

School transferring in from: _____



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 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.

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
Edition 2022

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

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

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature	Title	Date
Signature	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease	Signature	Title
--------------------	-----------	-------

3. Laboratory Evidence of Immunity (check one) Measles* Mumps** Rubella Varicella Attach copy of lab result.

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.

**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

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

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

ALLERGIES (Food, drug, insect, other)	Yes No	List:	MEDICATION (Prescribed or taken on a regular basis.)	Yes No	List:
Diagnosis of asthma?	Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Child wakes during night coughing?	Yes No		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		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Dizziness or chest pain with exercise?	Yes No		Information may be shared with appropriate personnel for health and educational purposes.		
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____			Parent/Guardian Signature _____ Date _____		
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)					
Ear/Hearing problems?	Yes No				
Bone/Joint problem/injury/scoliosis?	Yes No				

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

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

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

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

Questionnaire Administered? Yes No Blood Test Indicated? Yes No Blood Test Date _____ Result _____

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

No test needed Test performed Skin Test: Date Read _____ Result: Positive Negative mm _____

Blood Test: Date Reported _____ Result: Positive Negative Value _____

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

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears		Screening Result:	Gastrointestinal	
Eyes		Screening Result:	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
Cardiovascular/HTN			Nutritional status	
Respiratory		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	

Currently Prescribed Asthma Medication:
 Quick-relief medication (e.g. Short Acting Beta Agonist)
 Controller medication (e.g. inhaled corticosteroid)

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 _____



PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 666) 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent or Guardian:	Last Name	First Name		
Student's Race/Ethnicity:				
<input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown <input type="checkbox"/> 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: _____



GRADES 9 – 12
HIGH SCHOOL
ATHLETICS

PLEASE RETURN
THESE FORMS
SIGNED.

THANK YOU.

**Marquette Academy High 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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Basketball | <input type="checkbox"/> Scholastic Bowl |
| <input type="checkbox"/> Softball | <input type="checkbox"/> Cross Country | <input type="checkbox"/> Football |
| <input type="checkbox"/> Volleyball | <input type="checkbox"/> Cheerleading | <input type="checkbox"/> Golf |
| <input type="checkbox"/> Track & Field | <input type="checkbox"/> Wrestling | <input type="checkbox"/> Dance Team |
| <input type="checkbox"/> Other: _____ | | |

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 accepts the responsibility that comes with being a parent/guardian of a student athlete.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

MARQUETTE ACADEMY HIGH SCHOOL

CONSENT FORM REQUIRED OF ALL

PARENTS AND STUDENTS

I/We have read the policy statement regarding the mandatory screening for drug usage that is required of all students in attendance at Marquette Academy High School.

I/We understand that the school will request a hair sample of our son/daughter for the purpose of this screening and I/we agree that our son/daughter will submit a sample upon request at any time. I/We agree to the methodology being used for hair sampling and sharing the results with appropriate persons referred to in the policy. I/We further agree to defend and indemnify the high school and the Diocese of Peoria, their employees and agents, against any demands or claims of any type whatsoever (including the cost of attorney fees) asserted or based upon any liability arising in any way from or related in any way to the Drug Screening Program, or any acts, errors, or omissions relating thereto, by the student identified below whose attendance at the high school is conditioned upon execution of this consent.

I/We understand that failure to comply with this policy in any part or in whole constitutes cause for immediate dismissal from the school.

I/We agree to abide by the terms mandated by this policy if our son/daughter tests positive for the presence of a prohibited substance and will cooperate fully in obtaining an immediate assessment from a substance abuse professional. Furthermore, I/we agree to also cooperate with the particular plan of treatment or recovery that is recommended for our son/daughter.

I/We fully understand that refusal to sign this consent form renders our son/daughter ineligible for attendance at Marquette Academy High School.

Student's Name: _____

Student's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

**PERMISSION FORM FOR PARTICIPATION IN
MARQUETTE ACADEMY
CHRISTIAN SERVICE LEARNING PROGRAM
(9 - 12)**

I am the custodial and responsible parent/guardian of _____

I understand that the completion of 30 hours per year for the Christian Service Learning Program is a requirement before final exams as well as for graduation from Marquette Academy.

I understand that participation in acceptable project(s) is at the discretion of my son/daughter with my approval and that Marquette Academy assumes no responsibility for accident or injury involving the student or others while participating in a project outside school hours and not supervised by school personnel.

I understand the risks such participation presents to my child, including but not limited to, serious personal injury or death. Any questions I have concerning this program have been answered.

In consideration of my child being allowed to participate in this program, I hereby **RELEASE AND AGREE TO INDEMNIFY AND HOLD HARMLESS** the Diocese of Peoria, 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 attorneys' fees) arising from or related to my child's participation in this program.

I understand that the supervisor of this project will keep an accurate record of the student's hours and will, at the completion of the project, evaluate the student's performance.

Parent/Guardian

Date



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>.

GRADES 9 – 12
HIGH SCHOOL
ATHLETICS

PLEASE READ
AND KEEP THESE
FORMS.

THANK YOU.



Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

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

Signs observed by teammates, parents and coaches include:

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily or displays incoordination
- Answers questions slowly
- Slurred speech
- Shows behavior or personality changes
- Can't recall events prior to hit
- Can't recall events after hit
- Seizures or convulsions
- Any change in typical behavior or personality
- Loses consciousness



IHSA Sports Medicine Acknowledgement & Consent Form

Concussion Information Sheet (Cont.)

What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is the key to student-athlete's safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. The Youth Sports Concussion Safety Act requires athletes to complete the Return to Play (RTP) protocols for their school prior to returning to play or practice following a concussion or after being removed from an interscholastic contest due to a possible head injury or concussion and not cleared to return to that same contest.

You should also inform your child's coach if you think that your child may have a concussion. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:
<http://www.cdc.gov/ConcussionInYouthSports/>



IHSA Sports Medicine Acknowledgement & Consent Form

IHSA Performance-Enhancing Substance Policy

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

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

IHSA PES Policy

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

IHSA Banned Drug Classes

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