

PLAYER RECORD PACKET

INTRODUCTION

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

A completed Player Record Packet includes:

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

Additional Information that must be submitted for student eligibility:

- Medical Documentation Forms
 - **Within last 395 days** - State of Illinois Certificate of Child Health Examination - [English](#) (also included) **OR** IHSA Pre-participation Examination ([English](#) / [Spanish](#))
 - IHSA Sports Medicine Acknowledgement & Consent Form (**page 9**)

GENERAL INFORMATION

School: _____ Name: _____ Student ID: _____ Gender: _____
Date of Birth: _____ Current Age: _____ Address: _____
Emergency Contact Name & Relationship: _____
Emergency Contact Number(s): _____
Date of Enrollment this Semester: _____ Date of Initial Enrollment in High School: _____
Number of Semesters in Attendance in High Schools, Including Present Semester: _____

Are you a Transfer Student? Have you ever attended a different high school than the one you are currently attending? YES NO

Sport (circle all that apply):

Baseball Basketball Bowling Cross Country Competitive Cheer/Dance
Football Golf Lacrosse Soccer Softball/16in Swimming/Diving
Tennis Track and Field Volleyball Water Polo Other: _____

Athletic Participation History

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

BY-LAWS ACKNOWLEDGEMENT

I am in receipt of the [Chicago Public Schools Athletics Constitution and Bylaws](#) and agree that my child will abide by all of the Chicago Public League rules.

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

ATHLETIC ELIGIBILITY

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

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

TRANSPORTATION ACKNOWLEDGEMENT

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

****Optional****

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

Parent/Guardian Signature: _____

GENERAL CONSENT

Student Name: _____

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

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

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

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

Parent/Guardian Signature: _____ Date: _____

AUTHORIZATION FOR MEDICAL TREATMENT AND MEDICAL INFORMATION/DOCUMENTS

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

Parent/Guardian Signature: _____ Date: _____

Insurance Information **Optional**

Student Name: _____ Insurance Company: _____

Policy Holder Name: _____ Relationship to Student: _____

Policy Number: _____ Group: _____

Physician Name: _____ Physician Contact Number: _____

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

MEDIA ACKNOWLEDGEMENT

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

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

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

Parent/Guardian Signature: _____



State of Illinois
Certificate of Child Health Examination

Student's Name				Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#					
Last First Middle				Month/Day/Year								
Address Street City Zip Code				Parent/Guardian Telephone # Home Work								
IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <i>every</i> 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
DTP or DTaP												
Tdap; Td or Pediatric DT (Check specific type)	☐ Tdap	☐ Td	☐ DT	☐ Tdap	☐ Td	☐ DT	☐ Tdap	☐ Td	☐ DT	☐ Tdap	☐ Td	☐ DT
Polio (Check specific type)	☐ IPV		☐ OPV	☐ IPV		☐ OPV	☐ IPV		☐ OPV	☐ IPV		☐ OPV
Hib Haemophilus influenza type b												
Pneumococcal Conjugate												
Hepatitis B												
MMR Measles Mumps Rubella							Comments: * indicates invalid dose					
Varicella (Chickenpox)												
Meningococcal conjugate (MCV4)												
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose												
Hepatitis A												
HPV												
Influenza												
Other: Specify Immunization Administered/Dates												
Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.												
Signature				Title				Date				
Signature				Title				Date				
ALTERNATIVE PROOF OF IMMUNITY												
1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result. *MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR												
2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease. Date of Disease Signature Title												
3. Laboratory Evidence of Immunity (check one) ☐ Measles* ☐ Mumps** ☐ Rubella ☐ Varicella Attach copy of lab result. *All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence. **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.												
Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____ Physician Statements of Immunity MUST be submitted to IDPH for review.												

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



IHSA Sports Medicine Acknowledgement & Consent Form

Concussion Information Sheet

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

Symptoms may include one or more of the following:

- | | |
|--|--|
| <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/>

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



IHSA 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 and 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](#)

[IHSA Banned Drug Classes](#)



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.