THORNTON TOWNSHIP HIGH SCHOOL DISTRICT 205
465 EAST 170TH STREET SOUTH HOLLAND, IL 60473-3481
708.225.4000 FAX: 708.225.4004
www.district205.net

TO: Athletes and Parents of Athletes

FROM: District 205 Administration

RE: ATHLETES MANDATORY PARTICIPATION FEE

Our Board passed a resolution requiring a sports participation fee for all District 205 athletes at a cost of **$50.00** per student. One fee covers all sports in which your child participates.

The fee includes services of trainers for the sport, towels, and supplies. It also provides accident insurance that provides benefits to all athletes participating as a member of a school-sponsored athletic team in a regularly scheduled and approved practice session or game with other members of the team.

This fee is waived for the 2023-2024 school year if the student is registered through the early registration process.

If you have your own insurance, you must use it to its full capacity, then the insurance company administering the coverage will review the **EXCESS** fees not paid by your policy. **If you have no insurance,** this program will cover the expense. If you belong to an HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization, you must follow the proper procedures outlined by your applicable plan before this coverage can honor any medical expenses.

HOW TO FILE A CLAIM

In case of an accident, the athletic trainer must fill out an accident report. The Athletic Department must send home an accident claim form to the parent and it must be returned to the Athletic Department. **IMPORTANT!! Accidents must be reported within 20 days. Claim form must be submitted within 90 days.** Questions regarding benefits and coverage may be directed in writing or by calling Web-TPA, Inc., P.O. Box 2415 Grapevine, TX, 76099-2415, Phone 1-866-975-9468.

IN CONCLUSION

Parents should retain this letter for future reference recognizing that this benefit is available in the participation fee. Web-TPA, Inc., administers the coverage that is underwritten by the Gerber Life Insurance Company.

ATHLETIC DISCIPLINE CODE

1. **SCHOOL ATTENDANCE:** All participating athletes are expected to be in attendance at school at least half-day of any day they are to participate in practice or in a contest.
2. **SCHOOL INFRACTIONS:** Any school infraction which results in suspension from school will also result in suspension from an athletic activity at least until the student is properly reinstated in school.
3. **SMOKING OR DRINKING:** Any participating athlete identified by a school staff member as drinking or smoking will be given a minimum suspension from athletics of ten (10) school days from the date of the infraction. A repetition of such an incident will result in suspension from all athletics for the remainder of the school year.
4. **POSSESSION, SALE OR USE OF DRUGS:** Any participating athlete known to be in possession of drugs, selling drugs or using drugs will be suspended from any athletic involvement for the remainder of the school year.
5. **STEALING:** Any participating athlete involved in stealing of any nature will be suspended from athletics from first incident for a minimum of ten (10) school days and will make restitution for anything stolen. A repetition of such incident will result in suspension from all athletics for the remainder of the school year as restitution for anything stolen.
6. **FIGHTING OR ASSAULT:** Any fighting or assault by a participating athlete during an athletic contest will result in suspension from the athletic program for a minimum of five (5) school days and the severity of the incident, decided by the building administration, will determine if suspension from athletics for the year will take place. Any fighting or assault by a participating athlete during a practice session will result in suspension from the athletic program for a minimum of five (5) school days. A second such incident occurring during a practice session will result in suspension from all athletics for the remainder of the school year.
7. **DESTRUCTION OF DAMAGE OF PROPERTY:** Any destruction or damage to property associated with an athletic program will result in suspension of an athlete for a minimum of five (5) school days as well as payment of damages. A second such incident will result in suspension from all athletics for the remainder of the school year as well as payment of damages.
8. **TEAM RULES:** Violation of specific approved and distributed team rules other than those stated in this discipline code will be handled by the coach in charge.
9. **APPEAL:** Any participating athlete or coach may appeal a penalty to the Athletic Director or Assistant Athletic Director and if the problem is not resolved at that level, to the building Principal.
10. **AWARDS:** Awards for athletics may be withheld or refused if an athlete does not follow all the rules and regulations for a particular sport as announced to the athlete and approved by the school.

This discipline code will affect any athlete during the season in which the athlete is participating in a particular sport or for the school year if indicated in a particular part of the code. A second infraction does not refer to a second infraction in a given sport, but refers to a second infraction whenever it might take place.

2023-2024

THORNTON TOWNSHIP HIGH SCHOOL DISTRICT 205
THORNWOOD HIGH SCHOOL

PARENTAL PERMISSION CERTIFICATE

Athletic Office Use Only:
Academic Eligibility S1: Y N
Academic Eligibility S2: Y N
GPA: S1 _____ S2 _____
IHSA Drug: _____
Physical Date: _____
Part. Fee Date: _____
Concussion: _____

PLEASE PRINT IN INK-NO PENCIL

STUDENT ID NUMBER: _____ **YEAR IN SCHOOL: 9 10 11 12**

STUDENT'S NAME: _____
(FIRST) (LAST)

BIRTH DATE: _____ **BIRTH PLACE:** _____
(COUNTY) (STATE)

ADDRESS: _____
(STREET) (CITY) (ZIP)

HOME PHONE: ( ) _____ **FATHER'S CONTACT PHONE: ( )** _____

CELL PHONE: ( ) _____ **MOTHER'S CONTACT PHONE: ( )** _____

CIRCLE ALL SPORTS ATHLETE WILL TRYOUT AND/OR PARTICIPATE IN FOR THE CURRENT SCHOOL YEAR
****SPORT/SPORTS MUST BE CIRCLED TO PARTICIPATE****
MY SON/DAUGHTER HAS MY PERMISSION TO PARTICIPATE IN THE FOLLOWING SPORTS:

FALL	WINTER	SPRING
Cross Country-Boys	Basketball-Boys	Baseball
Cross Country-Girls	Basketball-Girls	*Soccer-Girls (TW)
Football	Competitive Cheer	Softball
*Soccer-Boys (TT)	Wrestling	*Tennis-Boys (TW)
*Tennis-Girls (TW)	Indoor Track-Boys	Outdoor Track-Boys
Volleyball	Indoor Track-Girls	Outdoor Track-Girls
Cheerleading	Competitive Dance	
Dance	*Swimming-Boys (TT)	
*Swimming-Girls (TT)	*Bowling-Boys/Girls (TR)	

Co-op Sports are held at Thornridge, Thornton, or Thornwood

I understand that I may cancel this permission at any time by sending a letter to the Athletic Director state such permission has been withdrawn.

_____
PARENT/GUARDIAN SIGNATURE

ATHLETIC DISCIPLINE CODE

I, _____ as a District 205Athlete, agree to abide by the Athletic Discipline Code (found on the reverse side of this form) during the school year in which I am participating in sports. I also understand that I am required to attend the "Hos to be a Champion" workshop which addresses character development prior to the first contest of my season.

_____
STUDENT SIGNATURE

We, as parents/guardians, agree to encourage and help our child to abide by these rules and requirements while participating in the District 205 Programs.

_____
PARENT/GUARDIAN SIGNATURE

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.

➢The student and parent/legal guardian further consent and authorize the school's ATC to provide appropriate therapeutic modalities in order to return student to athletic competition, such care to be conducted under the direction of a physician.

➢The student and parent/legal guardian further consent and authorize the school's ATC to administer baseline and/or post injury concussion management assessment in order to manage a concussion or suspected head trauma, such care to be conducted under the direction of a physician.

Parent Signature: _____ Student Signature: _____

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.

Post-concussion Consent Form (RTP/RTL)

Date _____

Student's Name _____ **Year in School** 9 10 11 12

By signing below, I acknowledge the following:

1. I have been informed concerning and consent to my student's participating in returning to play in accordance with the return-to-play and return-to-learn protocols established by Illinois State law;
2. I understand the risks associated with my student returning to play and returning to learn and will comply with any ongoing requirements in the return-to-play and return-to-learn protocols established by Illinois State law;
3. And I consent to the disclosure to appropriate persons, consistent with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), the written statement of the treating physician, athletic trainer, advanced practice nurse (APN), or physician assistant (PA) and, if any, the return-to-play and return-to-learn recommendations of the treating physician, athletic trainer, advanced practice nurse (APN), or physician assistant (PA), as the case may be.

Student's Signature _____

Parent/Guardian's Name _____

Parent/Guardian/s Signature _____

For School Use only

☐ Written statement is included with this consent from treating physician, advanced practice nurse (APN), physician assistant (PA) or athletic trainer working under the supervision of a physician that indicates, in the individual's professional judgement, it is safe for the student to return-to-play and return-to-learn.

Cleared for RTL

Date _____

Cleared for RTP

Date _____

ATHLETE EMERGENCY CONTACT FORM

COACHES PLEASE KEEP A COPY OF THIS ON YOU AND RETURN TO THE ATHLETIC DEPARTMENT

STUDENT INFORMATION:

Student Name: _____ ID Number: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____ Year in School (please circle): 9 10 11 12

EMERGENCY CONTACT INFORMATION: Please provide information for primary and alternative contact persons who may be notified in case of an emergency.

Name of Primary Contact: _____ Relation: _____

Address: _____ City: _____ Zip: _____

Primary Phone: _____ Alternate Phone: _____

Name of Alternate Contact: _____ Relation: _____

Address: _____ City: _____ Zip: _____

Primary Phone: _____ Alternate Phone: _____

CONDITIONS/ISSUES:

Please list any medical issues the student may have: i.e. asthma, allergies...

_____

_____

_____

The information requested on this form is confidential and for emergency use only. In the event of an emergency while participating in an athletic event, the information will be used by Thornwood High School Athletic Department personnel. Please provide accurate, complete and true information.

In case of an emergency, I give permission for my information to be released for emergency purposes. I also agree that any of my emergency contacts listed on this card may be notified in an emergency, as needed.

IHSA IESA

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

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

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

Explain "Yes" answers here.

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

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PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

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