WILDCATS XC

Information and FAQ

What is Cross Country in middle school?

- It is an interscholastic timed distance running competition run on various turfs (grass, concrete, dirt). The athlete is both running individually and as part of a team. In middle school, the race distance is 1.5 miles. It is a non-cut sport, so anyone interested and willing to put in the effort is on the team.

Do I need to be a good runner to join cross country?

- No, anyone can do cross country. All athletic ability is welcome, as long as they are willing to try and put in the effort at practice and meets.

What do I need to join cross country?

- An up to date physical must be on file with the school nurse PRIOR to the first practice, approximately August 28th.
- All permission forms and concussion forms signed and turned in to the coach prior to first practice.
- A good pair of running shoes and a water bottle is recommended.
- Good attitude and willingness to give it your all.

What do practice and meets look like?

- Practices are Monday, Tuesday, Thursday, and Friday each week. The season starts August 28th and ends approximately October 17th. Practice times go from 2:30-3:50pm .
- Meets start typically around 3-3:15 (depending on when the other schools arrive) and go until the last runner finishes the race. Typically there are four heats in the race, 7th grade girls, 7th grade boys, 8th grade girls, and 8th grade boys.

Coaches Information

- Emily Gora- emilygora@sd54.org
- BethParpet- bethparpet@sd54.org
- Marty Edwards- martyedwards@sd54.org
- Lance Leiva- lanceleiva@sd54.org

Cross Country

AUGUST/SEPTEMBER 2023

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
27	28 Cross Country Starts Today Practice 2:20-3:50	29 Practice 2:20-3:50	30	31 Practice 2:20-3:50	1 Practice 2:20-3:50	2
3	4 NO SCHOOL Labor Day	5 Practice 2:20-3:50	6	7 Parent Meeting 3:30 in Cafe Practice 2:20-3:50	8 Practice 2:20-3:50	9
10	11 Practice 2:20-3:50	12 Meet Keller @ Ike 8th grade runs first	13	14 Meet Addams @ Keller	15 CC Rain Date *IF Necessary* Practice 2:20-3:50	16
17	18 Meet Keller @ Frost	19 Meet Keller @ Mead	20 1/2 Day Inservice Day	21 Crusader Invite @ Addams (Only top 10 runners from each team)	22 CC Rain Date *IF Necessary* Practice 2:20-3:50	23
24	25 CC Rain Date *IF Necessary* Practice 2:20-3:50	26 Practice 2:20-3:50	27	28 Meet Ike @ Keller 2nd Round Starts Running order flips 7th grade runs first	29 CC Rain Date *IF Necessary* Practice 2:20-3:50	30

OCTOBER 2023

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
1	2 CC Rain Date *IF Necessary* Practice 2:20-3:50	3 Meet Keller @ Addams	4	5 Meet Frost @ Keller	6 CC Rain Date *IF Necessary* Practice 2:20-3:50	7
8	9  Columbus Day NO SCHOOL	10 Meet Keller @ Mead	11	12 Practice 2:20-3:50	13 CC Rain Date *IF Necessary* Practice 2:20-3:50	14
15	16 Practice 2:20-3:50	17 Cross Country Conference Meet @ Hoover	18	19 Cross Country Conference Meet Rain Date	20	21
22	23 Turn in jerseys to coaches this week	24	25	26	27	28

WILDCATS XC

- Practices end at 3:50. All students need to take the after school bus or be picked up by 4:00.
- Transportation will be provided to and from all* meets by District 54

*There may be a few meets where there will be no bus back to school (Crusader & Conference)

School District 54 INTERSCHOLASTIC SPORTS PERMISSION FORM

This permission slip and insurance coverage note must be returned to the coach and on file with the school before the student may tryout and participate in interscholastic sports.

Student's Name_____ **Grade**_____

Sport Cross Country

Interscholastic Sports Statement of Philosophy

It is the philosophy of the District 54 interscholastic program to provide a variety of opportunities to teach values in a competitive atmosphere while enhancing total fitness and character through organized activities. District 54 believes that interscholastic activities are an integral part of the educational process and allow for the development of skills in both group and individual experiences. The District believes that students participating in interscholastic sports will embrace the expectations of PBIS (*Positive Behavioral Interventions and Supports*) during their school hours and in their community at large.

Behavioral Expectations for Student Athletes

I am **RESPECTFUL** of my teammates, coaches, and opponents. I work at maintaining my positive attitude even in the face of the tremendous pressures of the game. I do not use profanity or make inappropriate comments toward my teammates or opponents. I respect my body by avoiding the use of dangerous and illegal substances.

I accept full **RESPONSIBILITY** for my actions. I am committed to doing my personal best on and off the field. When things get tough, I continue to focus on my goals. I am accountable for my behavior. I will demonstrate self-control and sportsmanship at practice, during contests, and throughout my life.

I will serve as a role model of **SAFE** behavior during practices and games. I will follow the rules and guidance from my coaches at all times. I will warm up and stretch before active competition and ensure to wear appropriate, properly-fitting sports gear.

NOTE: Board Policy 8:130/8:130-AP states in part: *Community Consolidated School District 54 does not grant permission to spectators to release personal tapings of productions for use on cable or other mass media.*

Attendance Requirements

Athletes **must** be dressed in a P.E. uniform and participate in P.E. class the day of practice/competition in order to participate in interscholastic sports.

Physical Examinations for Students Participating in Interscholastic Sports

Board Policy 7:300/7:300-AP states that physical examinations will be required for any student to try out for a team and participation in scheduled team practice or competition. A complete physical examination by a licensed physician, advanced practical nurse or physician assistant will cover a period of one year from the date of examination. A student's physical must be completed with proper forms and must be submitted to the school nurse. **Only students who have successfully and properly completed the physical examination will be permitted to tryout or participate in interscholastic sports.**

Athletic Program Participation Insurance Coverage Requirement

If you do not elect the insurance coverage made available to families by School District 54, a comparable insurance plan is required before your child may try out and participate in any interscholastic sports program. Your signature below will indicate that these requirements have been met.

Additional Health Information (please check all that apply):

Diabetes ___ Seizures ___ Concussions ___ Asthma___Allergies ____ Other (list)_____

Concussion Information Sheet

Each student and the student's parent/guardian must read and sign this *Agreement to Participate* each year before being allowed to participate in interscholastic sports or intramural athletics. The completed agreement should be returned to the coach.

My child, _____, wishes to participate in the following interscholastic sports or intramural athletics _____.

(An agreement must be signed for each sport the student joins.)

1. Physical examinations are required for any student to participate in intramurals, try out for a team and or participate in a scheduled team practice or competition. A complete physical examination by a licensed physician, advanced practical nurse or physician assistant will cover a period of one year from the date of examination. A student's physical must be completed with proper forms and must be submitted to the school nurse. Only students who have successfully and properly completed the physical examination will be permitted to try out or participate in interscholastic sports and/or intramurals.
2. The student agrees to abide by all conduct rules and will behave in a sportsman-like manner. The student agrees to follow the coaches' instructions, playing techniques and training schedule, as well as all safety rules.
3. The student and the student's parent/guardian understand that Board Policy 7:305 – Student Athlete Concussion and Head Injuries requires, among other things, that a student athlete who exhibits signs and symptoms, or behaviors consistent with a concussion or head injury must be removed from participation or competition at that time and that such student will not be allowed to return to play unless cleared to do so by an Illinois licensed physician.
4. The following Concussion Information Sheet explains concussion prevention, symptoms, treatment and guidelines, and includes guidelines for safely resuming participation in an athletic activity following a concussion.
5. The student and the student's parent/guardian are aware that with participation in sports comes the risk of injury, and that the degree of danger and seriousness of risk vary significantly from one sport to another, with contact sports carrying the highest risk. The student and the student's parent/guardian are aware that participating in sports involves travel with the team. The student and the student's parent/guardian acknowledge and accept the risks inherent in the sports or athletics in which the student will be participating and in all travel involved. The student and the student's parent/guardian agree to indemnify and hold the District, its employees, agents, coaches, School Board members, and volunteers harmless from any and all liability, actions, claims, or demands of any kind and nature whatsoever that may arise by or in connection with the student participating in the school-sponsored interscholastic sports or intramural athletics, to the extent allowed by law, including relating to physical injury to the student or others while participating in the above indicated sport or activity. The terms hereof shall serve as a release and assumption of risk for the student and the student's parent/guardian and their heirs, estate, executor, administrator, assignees, and for all members of the student and the student's parent/guardian's family. The parent/guardian certifies that the student is in good physical health and is capable of participation in the above indicated sport or activity.
6. If any term, covenant, condition, or provision of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated.

Concussion Information

Board Policy 7:305 – Concussion and Head Injuries requires, among other things, that a student athlete who exhibits signs and symptoms, or behaviors consistent with a concussion or head injury must be removed from participation or competition at that time and that such student will not be allowed to return to play unless cleared to do so by an Illinois licensed physician.

This Agreement to Participate and Concussion Information Sheet must be completed and signed each year by students and their parents/guardians (meaning the student's natural or adoptive parent or other legal guardian or person with legal authority to make medical decisions for the student) before the student may participate in interscholastic sports or intramural athletics for the school year. This form contains all language from the Concussion Information Sheet approved by the Illinois High School Association.

A concussion is a brain injury and all brain injuries are serious. Concussions 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 may include one or more of the following:

- 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

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 play or physical activity, including the physical activity portion of physical education courses, 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. IHSA Policy requires athletes to provide their school with written clearance from an Illinois licensed physician 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. Board policy requires clearance before such a student can return to intramural athletics and the physical activity portion of a physical education class.

You should also inform your child's coach if you think that your child may have a concussion, even if it resulted from an injury that occurred outside of school/school activities. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

How can you help your child prevent a concussion or other serious brain injury?

- Ensure that they follow their coach's rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity. Protective equipment should fit properly and be well maintained.
- Wearing a helmet is a must to reduce the risk of a serious brain injury or skull fracture.
- However, helmets are not designed to prevent concussions. There is no "concussion-proof" helmet. So, even with a helmet, it is important for kids and teens to avoid hits to the head.
- Tell your child's coaches if your child had a previous concussion. Your child's coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

For up-to-date information on concussions, visit https://www.cdc.gov/headsup/youthsports.

Adapted from the *IHSA Sports Medicine Acknowledgement & Consent Form*, which is adapted from the CDC and the 3rd International Conference on Concussion in Sports.

- ☐ I have read and agree to the *Behavioral Expectations for Student Athletes*.
- ☐ My child has permission to try out and participate in interscholastic sports.
- ☐ My child has a current physical (dated within one year) on file with the school nurse.
- ☐ My child does not have a current physical, but I will schedule an appointment before tryouts.

_____ _____

Student Athlete Signature Date

_____ _____

Parent Signature Date

_____ _____

Coach Signature Date

Emergency phone #_____ Alt. phone #_____

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	
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	

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	
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
Hemoglobin or Hematocrit		
Urinalysis		

	Date	Results
Sickle Cell (when indicated)		
Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs
Skin		
Ears		Screening Result:
Eyes		Screening Result:
Nose		
Throat		
Mouth/Dental		
Cardiovascular/HTN		
Respiratory		☐ Diagnosis of Asthma

	Normal	Comments/Follow-up/Needs
Endocrine		
Gastrointestinal		
Genito-Urinary		LMP
Neurological		
Musculoskeletal		
Spinal Exam		
Nutritional status		
Mental Health		
Other		

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**