Girls Volleyball 2025

Permission slips are due to your grade level coach by
Friday, December 13th at 3 pm.

7th grade coach- Ms. Bohne
8th grade coach- Mrs. Theander

Completed physicals are due no later than **Friday, December 13th** at **3 pm, turned into the nurse**. ***Please note that parents are required to sign the designated area on the physical form.***

- 8th Grade Tryouts will be Monday, January 6th from 2:15-3:45 pm
- 7th Grade Tryouts will be on Tuesday, January 7th from 2:15-3:45 pm
- Call backs for both grade levels will be on Thursday, January 9th from 2:15-3:45 pm.

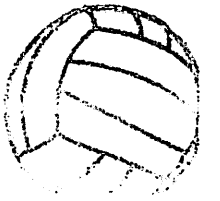
A 4:00pm bus will be available for girls who normally take the bus home. Otherwise, please arrange for proper transportation to arrive no later than 4:00pm for your child.

For tryouts, please change into workout clothes, remove **all** jewelry, and meet in the gym on your designated day.

If you have questions, please contact a coach below.

7th grade coach- Ms. Bohne (elizabethbohne@sd54.org)

8th grade coach- Ms. Theander (alexinatheander@sd54.org)



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 _____

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 (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#

Street Address / City / ZIP Code	Parent/Guardian / Telephone (home/work)

HEALTH HISTORY: MUST 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		Hospitalization? 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 disorder? 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				
Dizziness or chest pain with exercise?	☐ Yes ☐ No				

Eye/Vision problems? _____ ☐ Glasses ☐ Contacts Last exam by eye doctor _____

☐ Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other

Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) _____

Additional Information:

Ear/Hearing problems? ☐ Yes ☐ No

Bone/Joint problem/injury/scoliosis? ☐ Yes ☐ No

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

Parent/Guardian Signatures: _____ Date: _____

IMMUNIZATIONS: To be completed by health care provider. The mo/day/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 Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella						
Varicella (Chickenpox)						
Meningococcal Conjugate						
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 _____

Student's Name Last First Middle	Birth Date (Mo/Day/Yr)	Sex	School	Grade Level/ID#

Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.

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.

Physician Statements of Immunity MUST be submitted to IDPH for review.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____

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 aged 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	SCREENINGS	Date	Results
Hemoglobin or Hematocrit			Developmental Screening		☐ Completed ☐ N/A
Urinalysis			Social and Emotional Screening		☐ Completed ☐ N/A
Sickle Cell (when indicated			Other:		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin	☐		Endocrine	☐	
Ears	☐	Screening Result:	Gastrointestinal	☐	
Eyes	☐	Screening Result:	Genito-Urinary	☐	LMP:
Nose	☐		Neurological	☐	
Throat	☐		Musculoskeletal	☐	
Mouth/Dental	☐		Spinal Exam	☐	
Cardiovascular/HTN	☐		Nutritional Status	☐	
Respiratory	☐	☐ Diagnosis of Asthma	Mental Health	☐	
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g., Short Acting Beta Agonist) ☐ Controller medication (e.g., inhaled corticosteroid)			Other	☐	

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES (e.g., safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup)

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

☐ Yes ☐ No If yes, please describe:

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION ☐ Yes ☐ No ☐ Modified **INTERSCHOLASTIC SPORTS** ☐ Yes ☐ No ☐ Modified

Print Name _____ ☐ MD ☐ DO ☐ APN ☐ PA Signature _____ Date _____

Address Phone

Español

State of Illinois

Certificate of Child Health Examination

Student's Name (Last / First / Middle)	Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#

Street Address | City | ZIP Code | Parent/Guardian | Telephone (home/work)

HISTORIAL DE SALUD: DEBE SER COMPLETADO Y FIRMADO POR EL PADRE/TUTOR Y VERIFICADO POR EL PROVEEDOR DE ATENCIÓN MÉDICA.

ALERGIAS (Alimentos, drogas, insectos, otro)	☐ Sí ☐ No	Anote todas las alergias:	MEDICAMENTOS (Recetados o tomados con regularidad)	☐ Sí ☐ No	Anote todos los medicamentos:

¿Tiene diagnóstico de asthma?	☐ Sí ☐ No		¿Tiene pérdida de funciones en uno de los órganos?(Ojos/Oídos/Riñones/Testículos)	☐ Sí ☐ No	
¿Despierta el niño tosiendo en la noche?	☐ Sí ☐ No		¿Ha sido hospitalizado? ¿Cuándo? ¿Para qué?	☐ Sí ☐ No	
¿Tiene defectos de nacimiento?	☐ Sí ☐ No		¿Ha tenido alguna cirugía?(anótelas todas) ¿Cuándo? ¿Para qué?	☐ Sí ☐ No	
¿Tiene retrasos del desarrollo?	☐ Sí ☐ No		¿Ha tenido heridas graves o enfermedades?	☐ Sí ☐ No	
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro. Explique.	☐ Sí ☐ No		¿Prueba positiva de TB (Pasado o Presente)?	☐ Sí* ☐ No	*Si contestó sí, refiera al departamento de salud local
¿Tiene diabetes?	☐ Sí ☐ No		¿Enfermedad de TB (Pasado o Presente)?	☐ Sí* ☐ No	
¿Tiene heridas en la cabeza/golpe/desmayo?	☐ Sí ☐ No		¿Usa tabaco (tipo, frecuencia)?	☐ Sí ☐ No	
¿Tiene convulsiones? Cómo se manifiestan?	☐ Sí ☐ No		¿Toma alcohol/drogas?	☐ Sí ☐ No	
¿Tiene problemas cardiacos/Dificultad para respirar?	☐ Sí ☐ No		¿Historial de familiares de muerte repentina antes de los 50 años? ¿Causa?	☐ Sí ☐ No	
¿Tiene soplo en el corazón/presión arterial alta?	☐ Sí ☐ No				
¿Tiene mareos o dolor de pecho al hacer ejercicios?	☐ Sí ☐ No				

¿Problemas con los ojos/visión? _____ ☐ Lentes ☐ Lentes de Contacto Último examen _____

¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee) _____

¿Tiene problemas de los oídos/no oye bien?	☐ Sí ☐ No	
¿Tiene problemas de los huesos/articulaciones/heridas/ escoliosis?	☐ Sí ☐ No	

☐ Dental ☐ Frenos ☐ Puente ☐ Placas ☐ Otro

Información Adicional:

La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.

Firma del Padre/ Tutor: _____ Fecha: _____

por favor, complete

IMMUNIZATIONS: To be completed by health care provider. The mo/day/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 Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella						
Varicella (Chickenpox)						
Meningococcal Conjugate						
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 _____

Student's Name Last First Middle	Birth Date (Mo/Day/Yr)	Sex	School	Grade Level/ID#

Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.

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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 aged 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	SCREENINGS	Date	Results
Hemoglobin or Hematocrit			Developmental Screening		☐ Completed ☐ N/A
Urinalysis			Social and Emotional Screening		☐ Completed ☐ N/A
Sickle Cell (when indicated			Other:		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin	☐		Endocrine	☐	
Ears	☐	Screening Result:	Gastrointestinal	☐	
Eyes	☐	Screening Result:	Genito-Urinary	☐	LMP:
Nose	☐		Neurological	☐	
Throat	☐		Musculoskeletal	☐	
Mouth/Dental	☐		Spinal Exam	☐	
Cardiovascular/HTN	☐		Nutritional Status	☐	
Respiratory	☐	☐ Diagnosis of Asthma	Mental Health	☐	
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g., Short Acting Beta Agonist) ☐ Controller medication (e.g., inhaled corticosteroid)			Other	☐	
NEEDS/MODIFICATIONS required in the school setting			**DIETARY** Needs/Restrictions		

SPECIAL INSTRUCTIONS/DEVICES (e.g., safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup)

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

☐ Yes ☐ No If yes, please describe:

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION ☐ Yes ☐ No ☐ Modified **INTERSCHOLASTIC SPORTS** ☐ Yes ☐ No ☐ Modified

Print Name _____ ☐ MD ☐ DO ☐ APN ☐ PA Signature _____ Date _____

Address Phone

Helen Keller Junior High School
Girls' Volleyball

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Question and Answer Sheet

1. ARE YOU SELECTED BASED ON ABILITY ALONE?

No. The process of choosing a team is a selection, not really a tryout. First and foremost the athlete's grades in school are taken into consideration. You must be eligible to play all season. **Two D's** or one **F** during any week will exclude a player from practice and games the following week. Secondly, a good attitude is a **must**. Are you coachable and able to follow directions? Do you think only of yourself or are you a team player who supports and celebrates all your teammates? Lastly, we are looking for effort and commitment on the court; do you hustle, dive for the ball, and run hard during drills? These are some of the qualities we look for when building a team.

2. WHAT IS LOOKED FOR AS FAR AS ABILITY IS CONCERNED?

Ability to serve (overhand), forearm passing, setting, and all aspects of team play (ability to communicate respectfully to teammates, being coachable, and spatial awareness).

3. HOW OFTEN ARE PRACTICES AND WHEN DO THEY OCCUR?

Regular practices are every day after school, except for Wednesdays. Times are as follows: Monday, Tuesday, Thursday, and Friday 2:15-3:50 and ***possible*** Wednesday practices are from 3:20-4:45 (TBD based on end-of-season tournament results only). Players need to be at all practices in order to be on the team.

4. HOW MANY PLAYERS MAKE THE TEAM?

In recent years, rosters are between 12 – 14 players **per grade level**.

5. HOW MANY GAMES ARE THERE?

There will be approximately 9 games and the District 54 Tournament.

6. WHAT IS THE COST TO BE ON THE TEAM?

There are expenses such as: team shorts, proper shoes, kneepads, and the physical examination. Shorts will need to be purchased if you make the team, as part of the uniform (**they are required**). Options for shorts to purchase will be selected once the team is assembled. All team members must have the same shorts, **per uniform requirements**. For hygienic reasons, the school does not provide spandex shorts as part of the uniform. Each team member also has the option to purchase a team shirt/hoodie.

7. WHAT IS THE POLICY ON PHYSICAL EXAMS?

Physical exams are required to participate in any team sports. **A VALID AND CURRENT PHYSICAL FORM IS REQUIRED TO BE SUBMITTED TO THE NURSE BY December 13th, 2025.** Physicals are valid for one calendar year in District 54. **The physical form must be turned into the nurse for approval and participation throughout the entire sports season, including tryouts.**

PERMISSION SLIPS TO TRY OUT MUST BE TURNED IN TO MS. BOHNE OR MRS. THEANDER NO LATER THAN FRIDAY, DECEMBER 13th at 3 pm.

THERE WILL BE NO EXCEPTIONS FOR LATE PERMISSION SLIPS.

Contract will only be signed if you make the team

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Volleyball Team Contract

Volleyball is a TEAM sport! Everyone practices together and competes together. There is no separate practice. Every member of this team contributes to the success of the team at each practice and game. Therefore, it is important that you understand the rules and expectations that come with being a member of this team.

1. **Academics first.** Grades are the MOST important part of being an athlete! Keep your grades up, and you can practice and play in games each week.
2. **Commitment.** By making the team, you have made a promise to the team and to your coaches that you will be at every practice and every game. If you are going to miss practice or a game, parent/student contact MUST be made via email, phone, or written note. If someone misses two or more practices, is late to two or more practices, or does not appropriately communicate with coaches regarding absences, the player may be asked to sit for a game.
3. **Language and Behavior.** Everyone on this team is expected to treat every other member of the team and the coaches with respect. You will use proper language and behave properly at practices and games, both home and away. Anything less will not be tolerated. As a member of this team, you represent yourself, our school, the community, your teammates, and your coaches. Individuals whose behavior reflects poorly upon the team, the school, or the community will have a consequence.
4. **Sportsmanship.** The team will support each of its members as well as the members of other teams in games. The team will show respect for all opposing teams.
5. **Equipment.** ROPE shoes, socks, comfortable exercise clothes, and necessary uniform required at all times! It is your responsibility to bring all pieces of your uniform on game days or you do not get to play.
6. **Nutrition.** Make sure to bring water to practices and games. You may also bring a light, healthy snack.

_____ Student Signature _____ date

_____ Parent Signature _____ date

_____ Coach Signature _____ date

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Girls Volleyball 2025

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JANUARY 2025

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
29 Winter Break	30 Winter Break	31 Winter Break	1 Winter Break	2 Winter Break	3 Winter Break	4 Winter Break
5	6 8th grade try-outs 2:15-3:50p	7 7th grade try-outs 2:15p-3:50p	8 No practice	9 7th/8th grade call-backs #1 2:15p-3:50p	10 7th/8th grade call-backs #2 -OR- Practice #1 2:15p-3:35p Parent Meeting 3:45-4:00p	11
12	13 Practice #2 2:15p-3:50p	14 Practice #3 2:15p-3:50p	15 No practice	16 Practice #4 2:15p-3:50p	17 Practice #5 2:15p-3:50p	18
19	20 No School Martin Luther King Day	21 Lincoln Prairie @ Keller	22 No practice	23 Addams @ Keller	24 Practice #6 2:15p-3:50p	25
26	27 Practice #7 2:15p-3:50p	28 Keller @ Mead	29 No practice	30 Frost @ Keller	31 Practice #8 2:15p-3:50p	

Girls Volleyball 2025

FEBRUARY 2025

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
						1
2	3 Practice #9 2:15p-3:50p	4 Keller @ Ike	5 No practice	6 Practice #10 2:15p-3:50p GVB: 2nd Half of Season Starts 7th Plays first	7 Practice #11 2:15p-3:50p	8
9	10 Keller @ Addams	11 Mead @ Keller	12 No practice	13 Keller @ Frost	14 No practice Half-Day Inservice	15
16	17 NO SCHOOL President's Day	18 Practice #12 2:15p-3:50p	19 No practice	20 Ike @ Keller	21 Practice #13 2:15p-3:50p	22
23	24 Practice #14 2:15p-3:50p	25 GVB First Round Tourney @ Ike	26 No practice	27 GVB Semi-Finals Tourney @ Mead	28 GVB Finals Tourney @ Mead	