

Keller Wrestling Information Packet



When Do We Start?:

*January 6th, 2025

Where?:

*Keller activity room right after school (2:15-3:50)

What do I need to do before then?

- Detach this page, the wrestling information and procedures page, and schedule and turn in the School District 54 Interscholastic Sports Permission Form to the office or a coach before January 6th (the day before winter break at the latest)
- Make sure you have a current physical on file with the school nurse before January 6th
- Bring/wear comfortable clothes
- Keep your grades up
- Ask a coach if you have any questions

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Wrestling Information and Procedures

The following information is being provided so that the wrestlers, and parents of wrestlers, are informed of the procedures of the Keller Junior High wrestling program. We advise that parents sit down and read this document carefully with their athlete to ensure a positive and rewarding experience. We are excited to offer this opportunity to the students at Keller Junior High.

Split Squad

There is a Varsity and Junior Varsity (JV) team. Wrestlers will have a “wrestle-off” to determine who will be on Varsity and JV. The winner of the wrestle-off will be on Varsity. The second place winner for that weight class will be on JV. Any others will be exhibition wrestlers for that weight class. Wrestlers can challenge each other to be on Varsity and JV throughout the season.

Eligibility

The following standards and procedures have been developed to ensure uniformity for participating in after-school interscholastic sports programs.

To be academically eligible for the following week, a student may not be failing any class or have a D in more than one class. Students not meeting academic requirements will attend a study session during practice time supervised by the coach and will be ineligible for practice and competition that week.

Practice Schedule

Practices will be held daily (except Wednesdays) after school. Wrestlers unable to practice are to provide notice of the absence prior to practice. **If a wrestler has 3 unexcused absences, they will no longer be a part of the wrestling program.** Wrestlers can bring a note to school or contact one of the coaches via email or phone call. **It is imperative that a coach is notified PRIOR to a practice or meet.**

Our normal weekly practice schedule is as follows:

- Monday: 2:15-3:50*
- Tuesday: 2:15-3:50*
- Wednesday: No Practice
- Thursday: 2:15-3:50*
- Friday: 2:15-3:50*

The after school activity bus can take regular bus riders home after practice on Monday, Tuesday, Thursday, and Friday. During the beginning of the season it may be necessary to extend practice until 5:00 p.m. If this happens, wrestlers and parents will be notified ahead of time.

*At the beginning of the season, practice *may* be extended until 5:00 p.m. Since, there will be no activity bus, attendance past 4:00 pm will be optional, if a wrestler stays they will need to be picked up promptly at 5:00 pm.

Equipment

Wrestling shoes are recommended for all wrestlers. A mouth guard is encouraged if the student has braces to prevent injury to the mouth. Headgear is required for all wrestlers. The equipment can be purchased at the following locations:

- Dick's Sporting Goods
Streets of Woodfield
- Dick Pond Athletics
Roselle Road, Schaumburg

Meets and Transportation

Travel to and from athletic events will be provided by the school district with exception of the varsity and junior varsity tournaments (a bus will only bring the students to the tournament, but will not return to Keller).

Students may leave a wrestling meet with their parent/guardian after the meet is completed and the wrestling mats have been returned (for home meets).

A parent or guardian who chooses to take their child home from away meets will have to sign out with the coach after the completion of the meet. Generally meets will end anywhere between 4:30-5:00. Wrestlers who take the bus back to Keller, will be asked to make phone calls on the way back to arrange to be picked up.

Students are expected to be picked up immediately following a meet or practice at Keller.

Wrestling Meet information

Wrestling meets will begin around 3:30 p.m. During the first half of the season the order of matches will be as follows: 80-86-92-100-107-115-123-130-138-145-155-165-180-225-HWT. The order will be **REVERSED** for the second half of the season: HWT-225-180-165-155-145-138-130-123-115-107-100-92-86-80.

All home meets will be held in the Keller Junior High gymnasium. Wrestlers are expected to stay until the completion of all meets in support of their teammates.

Conduct and Behavior

As a member of the Keller wrestling program, your child will be a representative of the school. The behavior and conduct of your athlete is expected to follow the guidelines put forth in the Keller Student Manual. Any conduct or behavior violation will be dealt with on a case-by-case basis by the coaching staff and administration.

Lost or Stolen Equipment

The Keller coaching staff and administration will not accept responsibility for any lost or stolen equipment. It is **STRONGLY** encouraged that wrestlers not bring anything of significant value to school or practice. Secondly, wrestlers will be expected to lock any personal items in a locker (phones, iPods, etc.) during practice and away at meets. Finally, wrestlers need to keep track of all wrestling equipment as it is their responsibility to do so.



2025 WRESTLING PRACTICE AND MEET SCHEDULE

GOOGLE CLASSROOM CODE: 2snykt2

MONDAY 1/6	PRACTICE 2:15-3:50
TUESDAY 1/7	PRACTICE 2:15-3:50
THURSDAY 1/9	PRACTICE 2:15-3:50
FRIDAY 1/10	PRACTICE 2:15-3:50
MONDAY 1/13	PRACTICE 2:15-3:50
TUESDAY 1/14	PRACTICE 2:15-3:50
THURSDAY 1/16	PRACTICE 2:15-3:50
FRIDAY 1/17	PRACTICE 2:15-3:50
MONDAY 1/20	NO PRACTICE - MLK DAY
TUESDAY 1/21	PRACTICE 2:15-3:50
THURSDAY 1/23	AWAY MEET @ ADDAMS (WRESTLING ORDER IS *LIGHT TO HEAVY*)
FRIDAY 1/24	PRACTICE 2:15-3:50
MONDAY 1/27	PRACTICE 2:15-3:50
TUESDAY 1/28	HOME MEET VS. MEAD
THURSDAY 1/30	AWAY MEET @ FROST
FRIDAY 1/31	PRACTICE 2:15-3:50
MONDAY 2/3	PRACTICE 2:15-3:50
TUESDAY 2/4	HOME MEET VS EISENHOWER
THURSDAY 2/6	PRACTICE 2:15-3:50
FRIDAY 2/7	PRACTICE 2:15-3:50

MONDAY 2/10	HOME MEET VS. ADDAMS (WRESTLING ORDER FLIPS *HEAVY TO LIGHT*)
TUESDAY 2/11	AWAY MEET @ MEAD
THURSDAY 2/13	HOME MEET VS. FROST
FRIDAY 2/14	NO PRACTICE DUE TO ½ DAY
MONDAY 2/17	NO PRACTICE - PRESIDENT'S DAY
TUESDAY 2/18	PRACTICE 2:15-3:50
THURSDAY 2/20	AWAY MEET @ EISENHOWER
FRIDAY 2/21	PRACTICE 2:15-3:50
MONDAY 2/24	PRACTICE 2:15-3:50
TUESDAY 2/25	JV TOURNAMENT @ ADDAMS JH (BUSSES GO TO ADDAMS ONLY, STUDENTS MUST GET PICKED UP FROM ADDAMS)
THURSDAY 2/27	VARSITY TOURNAMENT @ ADDAMS JH (BUSSES GO TO ADDAMS ONLY, STUDENTS MUST GET PICKED UP FROM ADDAMS)

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.

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- 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 # _____



Certificate of Child Health Examination

Student's Name			Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#
Last	First	Middle				
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)	<input type="checkbox"/> Yes <input type="checkbox"/> No	List:	MEDICATION (Prescribed or taken on a regular basis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	List:
Diagnosis of Asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child wakes during night coughing?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Hospitalization? When? What for?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Birth Defects?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Surgery? (List all) When? What for?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Developmental delay?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Serious injury or illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No		TB skin test positive (past/present)?	<input type="checkbox"/> Yes* <input type="checkbox"/> No	*If yes, refer to local health department
Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No		TB disease (past or present)?	<input type="checkbox"/> Yes* <input type="checkbox"/> No	
Head injury/Concussion/Passed out?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Tobacco use (type, frequency)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Seizures? What are they like?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Alcohol/Drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart problem/Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Family history of sudden death before age 50? (Cause?)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart murmur/High blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts Last exam by eye doctor _____		
Dizziness or chest pain with exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading)			Additional Information:		
Ear/Hearing problems? <input type="checkbox"/> Yes <input type="checkbox"/> No			Information may be shared with appropriate personnel for health and educational purposes.		
Bone/Joint problem/injury/scoliosis? <input type="checkbox"/> Yes <input type="checkbox"/> No			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			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6					
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR			
DTP or DTaP																					
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			
Hib 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#
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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		<input type="checkbox"/> Completed <input type="checkbox"/> N/A
Urinalysis			Social and Emotional Screening		<input type="checkbox"/> Completed <input type="checkbox"/> N/A
Sickle Cell (when indicated)			Other:		

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

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 _____