



Olympia High School and Middle School ACTIVITIES Release Form



STUDENT INFORMATION

Student Name: _____
LAST
FIRST
MI

Student Address: _____

Home Phone: _____

Parents or Legal Guardians: _____

BIRTHDATE: _____
MONTH
DAY
YEAR

CURRENT GRADE: _____

Fee Information

Participation Fee—\$85.00 Unlimited Activities

MEDICAL INFORMATION

Family Doctor: _____ Phone: _____

Choice of Hospital: _____

Contact if Parent Unavailable: _____ Phone: _____

Health History YES NO Condition of History (ie. braces. Specific allergies)

	YES	NO	
Chronic/Recurrent Illness			
Kidney Injuries			
Heart Condition/Disease			
Diabetes			
Asthma			
Headaches or Convulsions			
Heat Exhaustion Problems			
Dental Appliances			
Neck Injuries			
Any Sudden Family Death			
Allergies to Medications			
Missing Organs			
Heart/Blood Pressure Problems			
Chest Pain w/exercise			
Dizziness/Fainting w/exercise			
Concussion or Unconsciousness			
Eyeglasses or Contact Lenses			
Medications			
Should be a sports Participant?			

In the event of an emergency requiring medical attention, I hereby grant permission to a physician or other hospital personnel designated by the Olympia Coaching Staff to attend to my son/daughter.

Signature of Parent/Guardian: _____

Student's Name		Birth Date		Sex	School	Grade Level/ID #
Last	First	Middle	Month/Day/ Year			

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)

MEDICATION (List all prescribed or taken on a regular basis.)

Diagnosis of asthma?	Yes	No	Indicate Severity	
Child wakes during the night coughing?	Yes	No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No
Birth complications/prematurity?	Yes	No	Hospitalizations?	Yes No
Developmental delay?	Yes	No	When? What for?	Yes No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	Surgery? (List all.) When? What for?	Yes No
Diabetes?	Yes	No	Serious injury or illness?	Yes No
Head injury/Concussion/Passed out?	Yes	No	TB skin test positive (past/present)?	Yes* No
Seizures? What are they like?	Yes	No	TB disease (past or present)?	Yes* No
Heart problem/Shortness of breath?	Yes	No	Tobacco use (type, frequency)?	Yes No
Heart murmur/High blood pressure?	Yes	No	Alcohol/Drug use?	Yes No
Dizziness or chest pain with exercise?	Yes	No	Family history of sudden death before age 50? (Cause?)	Yes No
Eye/Vision problems? ___ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor ___				
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				
Ear/Hearing problems?	Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other	
Bone/Joint problem/injury/scoliosis?	Yes	No	Other concerns?	

Information may be shared with appropriate personnel for health and educational purposes.
Parent/Guardian Signature _____ **Date** _____

Entire section below to be completed by MD/DO/APN/PA

PHYSICAL EXAMINATION REQUIREMENTS	HEAD CIRCUMFERENCE	HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING (Not required for daycare.) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> AF Risk Yes <input type="checkbox"/> No <input type="checkbox"/>					
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. Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ Blood Test Result _____ (If child resides in Chicago, blood test is required.)					
TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV, infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. <input type="checkbox"/> No Test Needed <input type="checkbox"/> Test performed Date Read / / Result mm					
LAB TESTS (Recommended)	Date	Results	Date	Results	mm
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		
SYSTEM REVIEW Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs		
Skin		Endocrine			
Ears		Gastrointestinal			
Eyes Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> Result _____		Genito-Urinary		LMP	
Anisometropia Yes <input type="checkbox"/> No <input type="checkbox"/> Referred to Ophthalmologist/Optommetrist Yes <input type="checkbox"/> No <input type="checkbox"/>		Neurological			
Nose		Musculoskeletal			
Throat		Spinal examination			
Mouth/Dental		Nutritional status			
Cardiovascular/HTN		Mental Health			
Respiratory		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** (for one year) Yes No **Limited**

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name _____

Signature _____

Date _____

Address _____

Phone _____

Activities Agreement

Olympia CUSD #16 believes it is the function of the activities program to provide activities which are interesting, wholesome, and enjoyable for all students. The overall objective of the program is to develop skills, sportsmanship, and a spirit of competitiveness for each participant. All parents/guardians and participants are asked to read and discuss the implications of participation in the high school and/or middle school activities program before signing this form.

Activities Code

(see Activities Code in Student Handbook or ask for a copy prior to signing)

As a student participant, I have received a copy of the Olympia Activities Code and have read and understand its contents. My son/daughter has my permission to practice and compete in the activities at Olympia High School and/or Olympia Middle School. I also approve of my son/daughter abiding by all the conditions of the Activity Code and the IHSA/IESA eligibility rules (found in the High School student handbook or on-line at www.ihsa.org & www.iesa.org). In addition, I realize such activity involves the potential for injury, which is inherent in all activities. I acknowledge that injuries may occur.

Date: _____

Signature of Student _____

Residency/Guardianship

I also verify that this student is living with his/her natural parents or legal guardians. I further understand that if my son/daughter is not living with both his/her parents, IHSA/IESA rules require the student to reside with his/her legal guardian to be able to compete athletically.

I agree to attach a copy of court filed legal documents as proof of legal guardianship, if necessary, due to divorce, legal separation, foster parent or adoptive parent status.

In the event residency/guardianship changes during the school year, the OHMS Activities Office **MUST** be notified immediately.

Date: _____

Signature of Parent/Guardian _____

PARENTAL PERMIT

Students are given the opportunity to participate in the following activities:

High School

Fall: Boys' Cross Country, Girls' Cross Country, Girls' Swimming, Football, Volleyball, Boys' Golf, Girls' Golf, Boys' Soccer, Cheerleading, Marching Band, Flags, Fall Play, Tech. Crew, FFA
Winter: Boys' Basketball, Girls' Basketball, Wrestling, Boys' Swimming, Cheerleading, Dance Team, Chorus, Speech, Jazz Band, Madrigals, Scholastic Bowl, Chess, Concert Band, Group Interpretation
Spring: Boys' Track, Girls' Track, Softball, Baseball, Girls' Soccer, Show Choir, Spring Musical, Tech. Crew

Middle School

Fall: Boys' Cross Country, Girls' Cross Country, Baseball, Softball, Girls' Basketball, Band
Winter: Boys' Basketball, Wrestling, Volleyball, Cheerleading, Dance, Chorus, Literacy, Chess, Drama
Spring: Boys' Track, Girls' Track, Scholastic Bowl

To participate in **High School activities**, students must be passing **ALL** courses each week and pass 3 of 4 courses per semester

To participate in **Middle School activities**, students must pass **ALL** courses each week

In addition to passing academic coursework, a parental and doctor's permission for athletics must be completed. Parents/Guardians must carry accident insurance or waiver for athletics. Parents/Guardians and student participants must also sign the Activities Agreement.

Doctor's Permit

Every student participating in Illinois High School Association (IHSA) or Illinois Elementary School Association (IESA) athletics must have a valid physical on file with the school. Physicals **MUST** be valid through an entire athletic season **PRIOR** to participation during that sport season (ex. Physical **MUST** be valid entire wrestling season to be able to **START** wrestling practice/season). Physicals are valid for 1 year (365 days) from the date of examination.

Insurance Release

Waiver

We, the undersigned parents/guardians of _____, a student at Olympia CUSD #16 Stanford, Illinois, who desires to participate in school sponsored activities for which accident insurance is required by the Board of Education, hereby certify that such student is covered by accident insurance with the following company and which policy we agree to keep in effect throughout the current school year:

Insurance Company: _____

Insurance Policy Number: _____

We, therefore, do not want said student included in any accident insurance plan provided by the school; and we hereby waive any claim against said school, and the officers and employees thereof for reimbursement for any expense incurred on account of any accidental injury to said student may suffer while participating in such activities.

Date: _____

Signature of Parent/Guardian: _____

School Insurance Receipt

Accident insurance has been purchased as specified by the school for the current year. The student may be issued equipment and be permitted to practice.

Insurance Plan

School Time Coverage: _____ 24 Hour Coverage: _____ Football Coverage: _____ School Verification: _____