Argo Community High School

7329 West 63rd Street
Summit, IL 60501-1829
Phone (708)467-5500 Fax (708)728-3233
www.argohs.net

June 2016 (Freshmen, Transfer, & Students that do not qualify for online registration)

Dear Parent/Guardian:

We want to welcome you to the 2016-2017 school year. Enclosed in this packet is important information regarding **registration for your student**. Please make sure that all forms are completed so that our registration process will run smoothly. Please note the registration dates and times. **You and your son/daughter must attend registration together in order to receive their new ID, student handbook, and schedule.**

It is required that the Health and Dental forms be completed PRIOR to your son or daughter starting school.

The first day of school for freshmen and transfer students will be Wednesday, August 17, 2016, at 8:00 a.m.

This "Freshmen/Transfer Only" day will be held to introduce our new Argonauts to the building and the staff. **The first full day for all students will be Thursday, August 18, 2016. Students will be dismissed at 10:50 a.m.**

The attached packet has information that will make the registration process go smoothly and will provide information for the next year. As you read the packet, please give Mr. William Toulios, Assistant Principal, (708-467-5501) a call if you have any questions. We will be happy to discuss any questions you may have regarding registration and the 2016-2017 school year.

For freshmen, transfer students, and students that do not qualify for online registration, registration dates will be August 9th-11th from 12 p.m.-6 p.m.

On behalf of all of our faculty and staff, please accept our sincere hopes that the 2016-2017 school year will be a year of success for your student. We have been planning for the upcoming school year since January and anticipate a great learning environment for your student.

Sincerely,

Dr. Kevin J. O'Mara
Superintendent

Parent/Guardian Checklist for Registration

*The student AND parent/legal guardian must be present at registration.

CATEGORY I: (please provide the documents listed from one of two sections listed below)

_____ **HOMEOWNERS:** Copy of a **CURRENT**

- ✓ ____ mortgage statement/ property tax bill.

_____ **RENTERS**: Copy of a **CURRENT**

- ✓ ____ signed and dated current lease,
- ✓ ____ proof of last two months' payments, and
- ✓ ____ tenant verification form. **if you live in Willow Hills or Sunset Lakes you do not need a tenant verification form**

CATEGORY II: (please provide one CURRENT document PER GROUP showing the resident's address from each of the following three groups)

Group One:

- ✓ _____ Home Insurance Policy
- ✓ _____ Apartment Insurance Policy
- ✓ _____ Life Insurance Policy
- ✓ _____ Public Aid Card
- ✓ _____ Vehicle Registration

Group Two:

- ✓ _____ Driver's License or State I.D. (with in-district address)
- ✓ _____ Matricula (with in-district address)

Group Three:

- ✓ _____ Gas Bill
- ✓ _____ Water Bill
- ✓ _____ Electric Bill

CATEGORY III: (for incoming freshmen and transfer students)

- ✓ _____ Birth Certificate
- ✓ _____ Physical & Immunization Records

***The following items are UNACCEPTABLE for proving residency:**

- Cell phone bill
- Bank statement
- Cable bill/ Internet bill

***Students that are transferring in from another district must have an:**

- **ISBE transfer form marked in "good standing"**
- **a birth certificate**
- **physical and immunization records (refer to requirements for Health Services)**
- **An 8th grade diploma (if they are an incoming freshmen from a school outside of our district)**

Incoming and Transfer students: Requirements from Health Services for Registration 2016-2017

Incoming freshmen: All incoming freshmen are required to submit at registration a current physical on the State of Illinois Certificate of Child Health and an up to date immunization record. The record needs to include:

- ✓ two MMR
- ✓ two Varicella
- ✓ TDap.

Transfer Student Requirements: Students transferring in from another school in Illinois must bring a copy of their 9th grade physical and a complete and current up-to-date immunization record from their transferring school. Students transferring from out of the country must have a new physical on the State of Illinois Certificate of Child Health Examination form with a complete and current immunization record. An eye examination record or the Eye Examination Waiver is to be completed also.

Students entering 12th grade and subsequent grades are required to have obtained a meningitis vaccination after the age of 16 and submit written proof from a health care provider.

Dental Examinations are recommended but not required.

All forms are available on the Health Services website or in Health Services room 142.

Any questions/concerns please contact Health Services at 708-467-5647 or 5648.

Tenant Verification

(Renters Only)

Name of landlord:_____

Address: _____

Phone: _____

A copy of the <u>current lease is required.</u>

Please verify the validity and existence of the said lease by signing below.

Verification

<u>To be completed by Landlord/Leasing Manager:</u>
I hereby attest that the information as stated above regarding the rental of _____
Address
by _____ is true and correct.
Parent/Guardian

☐ I cannot verify as true and correct.

Please Read Before You Sign

It is the policy of the Board of Education of District 217 to admit only students who legally reside with their parents/guardians within the District. The information provided will be used by school officials to establish the eligibility of the above student applicant for admission. Falsification of any information regarding the residence of any of the persons listed will result in the student being excluded from school and is a Class C misdemeanor. Those making or giving such false information are liable for the payment of tuition to Argo Community High School District 217 for such time that the student was illegally attending.

I further certify that the information provided above is correct, and I have read and understand the warning about falsification of information and the possible consequences of providing false information.

Signature: _____ Date: _____
Landlord/Leasing Manager

Subscribed and sworn before me on the _____ day of _____2016.

Seal

_____
NOTARY PUBLIC

_____
NOTARY NUMBER

RESIDENCY

2016-2017 Registration/Emergency Information

Please Print

Last Name: _____ First Name: _____Middle Name:_____

Address: _____Apt #:_____

City: _____ Zip: _____Home #:_____

Student's Birthday: _____Ethnic Background: _____

Student's E-mail: _____

Gender : Male ☐ Female ☐ **Status:** IEP ☐ 504 ☐ ELL ☐ Orphan ☐

Guardianship-Student lives with: _____

B=Both Parents **G=Guardian** **M=Mother** **F=Father**

Mother's Name: _____ Home Phone: _____

Mother's Employer: _____ Work Phone: _____

Mother's Cell: _____ Mother's E-mail: _____

Father's Name: _____ Home Phone: _____

Father's Employer: _____ Work Phone: _____

Father's Cell: _____ Father's E-mail: _____

Guardian's Name: _____ Home Phone: _____

Guardian's Employer: _____ Work Phone: _____

Guardian's Cell: _____ Guardian's E-mail: _____

Language spoken in home: _____

Emergency Contact Information

Contact #1

Name: _____ Relationship: _____

Phone: _____ Type of phone: _____

Contact #2

Name: _____ Relationship: _____

Phone: _____ Type of phone: _____

Contact #3

Name: _____ Relationship: _____

Phone: _____ Type of phone: _____

Previous school information

Last grade in school attended: _____ Dates Attended: 20 ____ to 20___

Name of school entering from: _____City: _____, State: _____

***I verify that the above information is correct: _____**

Parent/Guardian signature

DEMOGRAPHICS

Medical Information

Student Name: _____

Physician's Name: _____

Physician's Phone Number: _____

Known Health Problems: _____

_____

_____

Medications (Time & Frequency): _____

_____

_____

Allergies: _____

_____

_____

Parent Signature: _____ Date: _____

Parent/Guardian authorization to share the above medical information with faculty and staff on the confidential list:

Parent Signature: _____ Date: _____

*******The health aide is here to care for students who become ill or injured while at school. The health aide is not here to diagnose conditions or give treatments to injuries which have occurred at home or elsewhere. Please refrain from sending your child to school with an injury or illness with the expectation that our health aide will take the place of your family physician.*******

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:

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		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during night coughing?	Yes	No					
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	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	*If yes, refer to local health department.
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 ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes			
Bone/Joint problem/injury/scoliosis?	Yes	No		**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** **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		Date	Results
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		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**

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

Address _____
(Number) (Street) (City) (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: ❑ Normal or Positive for _____

Medical history: ❑ Normal or Positive for _____

Drug allergies: ❑ NKDA or Allergic to _____

Other information _____

Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	_____
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	_____
Pupillary reflex (pupils)	❑	❑	❑	_____
Binocular function (stereopsis)	❑	❑	❑	_____
Accommodation and vergence	❑	❑	❑	_____
Color vision	❑	❑	❑	_____
Glaucoma evaluation	❑	❑	❑	_____
Oculomotor assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other _____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts should be worn for:
   ❑ Constant wear ❑ Near vision ❑ Far vision
   ❑ May be removed for physical education

2. Preferential seating recommended: ❑ No ❑ Yes

   Comments _____

   _____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months

   ❑ Other _____

4. _____

5. _____

Print name _____

Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

License Number _____

Address _____

_____

Phone _____

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

_____

(Parent or Guardian's Signature)

_____

(Date)

Signature _____

Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Printed by Authority of the State of Illinois
6/09

IOCI1271-09

State of Illinois
Department of Public Health
Eye Examination Waiver Form

Please print:

Student Name _____ Birth Date _____
(Last) (First) (Middle Initial) (Month/Day/Year)

School Name _____ Grade Level _____ Gender ❑ Male ❑ Female

Address _____
(Number) (Street) (City) (ZIP Code)

Phone _____
(Area Code)

Parent or Guardian _____
(Last) (First)

Address of Parent or Guardian _____
(Number) (Street) (City) (ZIP Code)

I am unable to obtain the required vision examination because:

❑ My child is enrolled in medical assistance/ALL KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community who is able to examine my child and accepts medical assistance/ALL KIDS.

❑ My child does not have any type of medical or vision/eye care coverage, my child does not qualify for medical assistance/ALL KIDS, there are no low-cost vision/eye clinics in our community that will see my child, and I have exhausted all other means and do not have sufficient income to provide my child with an eye examination.

❑ Other undue burden or a lack of access to an optometrist or to a physician who provides eye examinations: _____

_____

Signature _____ Date _____

(Source: Added at 32 Ill. Reg. _____, effective _____)

Printed by Authority of the State of Illinois
6/09

IOCI1271-09

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year) / /
Address: Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:		Gender: ☐ Male ☐ Female
Parent or Guardian:	Address (of parent/guardian):		

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note _____

Signature of Dentist _____ Date of Exam _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

NURSE

Physician/Parent Authorization Form: Over-the Counter and Prescription Medication

(All items need to be completed in detail by the physician. Physician and parent signature required.)

Approved by the health aide to begin administration on: _____

Student's Name _____ DOB: _____ Grade: _____

To be completed by the physician or authorized prescriber:

Diagnosis requiring medication: _____

Reason for medication during school hours: _____

_____

Name of medication: _____

Dosage: _____ Frequency: _____ Time to be given: _____

Start of administration: _____ Discontinuation date: _____

Restrictions and/or important side effects: ( ) None anticipated

( ) Yes, please describe _____

Other medication the student is receiving _____

Inhalers and Epi-pens may be self-administered in emergencies (please complete the following):
This student is both capable and responsible for self-administering this medication:

( ) No ( ) Yes, supervised

This student may carry this medication on him/her.

( ) No ( ) Yes

Physician's Name (print): _____

Address: _____ Phone: _____

Physician's Signature: _____ Date: _____

To be completed by parent/guardian:

I give permission for (student) _____

to receive the above medication at school according to school policy.

SIGNATURE _____ Date_____

(Inhalers require only parental authorization and a copy of the prescription)

NURSE

Illinois State Board of Education
New U.S. Department of Education Race and Ethnicity Data Standards

Student's Name:_____ **ID #:** _____

INSTRUCTIONS: This form is to be filled out by the student's parents or guardians, and both questions must be answered. Part A asks about the student's ethnicity and Part B asks about the student's race. If you decline to respond to either question, the school district is required to provide the missing information by observer identification.

Part A. Is this student Hispanic/Latino?
(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) **Choose only one.**

☐ **No, not Hispanic/Latino**

☐ **Yes, Hispanic/Latino**

The question above is about ethnicity, not race. No matter which answer you selected, continue and respond to the question below by marking one or more boxes to indicate what you consider this student's race to be.

Part B. What is the student's race? <u>Choose one or more.</u>

☐ **American Indian or Alaska Native** (A person having origins in any of the original people of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)

☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)

☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original Peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

DEMOGRAPHICS

RELEASE OF STUDENT INFORMATION "OPT OUT" FORM

Argo Community High School District #217 periodically releases information about students as allowed or required by law. If you do not want the District to release some or all of the information about your student described below, complete, sign, and return this form to the Principal's office by August 31, 2016. **Otherwise, we will presume that you consent to the release of all information described below.** Your consent is effective until you complete a new form, even after your child graduates from or leaves the District.

Directory Information

The District may release your student's "directory information" to the general public unless you indicate in this section that do you do not want such information released. The following information regarding the student is directory information: name; address; gender; grade level; birth date and place; parents'/guardians' names, mailing addresses, electronic mail addresses, and telephone numbers; academic awards, degrees, and honors; information in relation to school-sponsored activities, organizations, and athletics; period of attendance in the school; and photographs, videos, or digital images used for informational or news-related purposes of a student participating in school or school-sponsored activities, organizations, and athletics that have appeared in school publications, such as yearbooks, newspapers, or sporting of fine arts programs.

☐ I do NOT allow the District to release directory information about my child. **I understand that my child will not be included in the school yearbook (including team photos), newspaper, websites, or other publications.**

Military and Higher Education Recruitment Information

In accordance with Section 8025 of the *Every Student Succeeds Act* and Section 10-20.5a of the *Illinois School Code*, the District will release student names, addresses, and telephone numbers to military recruiters and institutions of higher education upon request unless you indicate in this section that you do not want such information released. Information received by military recruiting representatives shall be used only to provide information to students about military career and educational opportunities.

☐ I do NOT allow the District to release my child's name, address, or telephone number to: (check either or both)

☐ recruiters from the armed forces; and/or ☐ representatives of institutions of higher education.

Student Photographs, Audio Recordings, and Video Recordings

Certain photographs, audio recordings, and video recordings of your child may be released to third parties, published publicly, and used by the District even if you check the box below. This includes photographs, audio recordings, and video recordings: (1) that do not feature your child but in which your child appears in the background; and (2) that are taken of your child participating in an extracurricular activity the very nature of which involves exposure to the public (e.g, athletic events and theatrical productions open to the public). The District may release, publish, and use all other photographs, audio recordings, and video recordings of your child, including without limitation publication in school and District publications, websites, and social media platforms, unless you indicate otherwise in this section.

☐ I do NOT allow the District to release, publish, or use photographs, audio recordings, or video recordings of my child as described in this section. I understand that the District can still use photographs, audio recordings, and video recordings that do not feature my child or of my child participating in a public activity even if I check this box. **I understand that checking this box means my child will not be included the school yearbook (including team photos), newspaper, websites, or other publications.**

_____	_____	_____	_____
Print Student Name	ID Number (**required**)	Signature of Parent/Guardian	Date

_____	_____
Signature of Student	Date

(For office use only)

_____ _____

Date Received Date Processed

DEMOGRAPHICS

Military Family Form

Pursuant to Section 22-70 of the Illinois School Code (below), the State of Illinois is requiring that all Illinois School Districts provide the opportunity to voluntarily state whether the student has a parent or guardian who is a member of the armed forces of the United States and who is either deployed to active duty or expects to be deployed to active duty during the school year. This information is to be reported as aggregate data to the Illinois State Board of Education.

Please answer the question below and return.

Thank you.

Student Name: _____ Grade: _____

Does your student have a parent or guardian who is a member of the U.S. Military who is either deployed to active duty or expects to be deployed to active duty during the school year?

☐ Yes ☐ No ☐ Choose not to disclose

Branch of Service:

☐ U.S. Air Force ☐ Army ☐ U.S. Coast Guard

☐ U.S. Marines ☐ U.S. National Guard ☐ U.S. Navy

Month(s) of Deployment:

☐ **Jan** ☐ **Feb** ☐ **Mar** ☐ **Apr** ☐ **May** ☐ **Jun** ☐ **July** ☐ **Aug** ☐ **Sept** ☐ **Oct** ☐ **Nov** ☐ **Dec**

(105 ILCS 5/22-70)

Sec. 22-70. Enrollment information; children of military personnel. At the time of annual enrollment or at any time during the school year, a school district or a recognized non-public school, except for sectarian non-public schools, serving any of grades kindergarten through 12 shall provide, either on its standard enrollment form or on a separate form, the opportunity for the individual enrolling the student to voluntarily state whether the student has a parent or guardian who is a member of a branch of the armed forces of the United States and who is either deployed to active duty or expects to be deployed to active duty during the school year. Each school district and recognized non-public school shall report this enrollment information as aggregate data to the State Board of Education.
(Source: P.A. 97-505, eff. 8-23-11; 97-813, eff. 7-13-12.)

Please notify the school of any changes or updates to your information.

Office Use: Revised: February 2016

Date Provided _____/_____/_____

DEMOGRAPHICS

Fees:

Registration Fee: **$150.00**

Technology Fee: **$50.00**

Required Physical Education Uniform: **$15.50** **(plus tax)**
If students have uniforms from previous years, purchase not required

Required Hall and Physical Education Locks: **$6.00** **(plus tax)**
If students have locks from previous years, purchase not required

Yearbook (optional) **$45.00**
Yearbooks may also be purchased during the school year for $55.00

Driver's Education – Sophomores **$75.00**
If your student is taking Driver's Education, this is a required fee that is to be paid at registration.

Fee Waivers:

Families may be eligible to have the registration fee waived if they meet income requirements. Documentation is required at the time of registration. If you have a Medicaid card from Department of Human Services, within the past 30 days prior to registration (either July or August) that lists the student(s) name as eligible for benefits, please be sure to present this during registration. This does not automatically qualify for the waiver as we may still need proof of income. If you do have household income, please bring documentation including the two most recent pay stubs (within 30-45 days), social security benefit letters or evidence of amount being deposited electronically to your bank for all members of the household or formal letters that state the amount of financial assistance a household receives. If you have seasonal overtime or fluctuating income you must bring in your annual federal income tax filing IRS Form 1040 from the prior year. Failure to bring appropriate documentation will preclude us from being able to consider a waiver approval during registration. Should you have any questions in advance of the registration time you may contact the Business Office at 708-467-5500.

Bus Schedules:

Bus schedules will be distributed at registration.

Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name_____ School Year_____
Last First Middle

Address_____ City/State_____

Phone No._____ Birthdate_____ Age_____ Class_____ Student ID No._____

Parent's Name_____ Phone No._____

Address_____ City/State_____

HISTORY FORM

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other:		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Have you or any family member or relative been diagnosed with cancer?		
52. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**Yes**	**No**
53. Have you ever had a menstrual period?		
54. How old were you when you had your first menstrual period?		
55. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of athlete_____ **Signature of parent/guardian**_____ **Date**_____

Pre-participation Examination

PHYSICAL EXAMINATION FORM Name _____ (Last / First / Middle)

EXAMINATION		
Height / Weight / ☐ Male ☐ Female		
BP / (/) Pulse / Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/Ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b] Consider GU exam if in private setting. Having third party present is recommended.
[c] Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for 395 days from this date.

Yes _____ No _____ Limited _____ Examination Date _____

Additional Comments:

Physician's Signature _____ Physician's Name _____

Physician's Assistant Signature* _____ PA's Name _____

Advanced Nurse Practitioner's Signature* _____ ANP's Name _____

*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

Argo Community High School District 217 7329 West 63rd Street, Summit, IL 60501 (708) 467-5500

2016-2017 Athletic/Activity Agreement

*Instructions: Carefully read all items and **PRINT** all information.*

Name_____ Student ID#_____

Address_____ Apt/Bldg/Unit #_____

City_____ Zip Code_____ Home Phone_____

Place of Birth_____ Date of Birth_____

Present year in school *(Check One):* ☐ Senior ☐ Junior ☐ Sophomore ☐ Freshman

TO THE PARENTS:

1. **Eligibility:** In order for a student to be eligible to participate in the high school athletic/activity program in the State of Illinois, he/she must have successfully completed and received credit for 25 hours (5 academic subjects) of class work during his/her last semester of high school attendance. Also, he/she is required to make passing grades in at least 25 hours of schoolwork each week during the current semester of his/her participation. No student may participate in any sport for more than 4 seasons.
2. **Residence:** The parents or legal guardian of the student participating in interscholastic athletics/activities at Argo Community High School must be a resident in the high school district in which he/she attends school, namely District 217. The term "resident" includes person(s) who have established a permanent home and actually live in it physically. A mere declaration of intention to establish a home for the purpose of voting is not sufficient.
3. **Physical Examination:** Each student who wishes to participate in the athletic program at Argo Community High School must have a doctor's certificate of physical fitness issued just prior to the beginning of the school year or prior to the particular sport season.
4. **Student Insurance:** School District 217 recommends that all student athletes have hospitalization insurance. If you wish to purchase student accident insurance, you may contact any insurance broker of your choice.

   School District 217 does not accept liability for athletic/activity related injuries.

5. **Training Regulations:** In order for any student to participate in the ACHS Athletic/Activity Program, he/she must adhere to the training rules, including the School Pledge Program outlined in the Student Calendar Handbook, approved by the program. The coaches and the entire Athletic Department will appreciate the whole-hearted cooperation of parents in support of the conduct standards and training regulations for Argo athletes. Students must be in attendance on school days to participate in activities, games, practice, or any school event.

Parent's Permission: I HEREBY GIVE APPROVAL FOR MY SON/DAUGHTER TO PARTICIPATE IN:

_____ at ACHS in accordance with the provisions and regulations.
Sport/Activity

_____ _____ Cell Phone # (_____)_____
Signature of Parent/Guardian *Date*

Emergency Phone # (____)_____

TO THE STUDENT:

Student's Athletic/Activity Agreement: I hereby request permission to take part in the athletic/activity program at ACHS with full understanding that I will keep myself physically fit and observe the conduct and training rules as prescribed by the Athletic Department. I am fully aware that any infraction of the training rules may result in suspension from the athletic program. I will assume all responsibility for athletic equipment issued to me and agree to pay for any lost, stolen, or damaged equipment, except from ordinary usage. I shall also agree to turn in my equipment immediately at the conclusion of the season or if for any reason I should decide to withdraw from the program. **I understand I cannot quit to join another sport in the same season, unless permission is granted from both coaches involved.**

_____ _____
Signature of Student ***Date***

PLEASE RETURN COMPLETED IHSA PHYSICAL FORM TO THE ATHLETIC OFFICE WITH THIS FORM.

IHSA Sports Medicine Acknowledgement & Consent Form

Acknowledgement and Consent

Student/Parent Consent and Acknowledgements

By signing this form, we acknowledge we have been provided information regarding concussions and the IHSA Performance-Enhancing Testing Policy. We also acknowledge that we are providing consent to be tested in accordance with the procedures outlined in the IHSA Performance-Enhancing Testing Policy.

STUDENT

Student Name (Print): _____ Grade (9-12) _____

Student Signature: _____ Date: _____

PARENT or LEGAL GUARDIAN

Name (Print): _____

Signature: _____ Date: _____

Relationship to student: _____

Consent to Self Administer Asthma Medication

Illinois Public Act 098-0795 provides new directions for schools concerning the self-carry and self-administration of asthma medication by students. In order for students to carry and self-administer asthma medication, parents or guardians must provide schools with the following:

- Written authorization from a student's parents or guardians to allow the student to self-carry and self-administer the medication.
- The prescription label, which must contain the name of the asthma medication, the prescribed dosage, and the time at which or circumstances under which the asthma medication is to be administered.

A full copy of the law can be found at http://www.ilga.gov/legislation/publicacts/98/PDF/098-0795.pdf.

Each year IHSA member schools are required to keep a signed Acknowledgement and Consent form and a current Pre-participation Physical Examination on file for all student athletes.

Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They 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 include:

- 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

Concussion Information Sheet (Cont.)

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 activity 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 either a physician licensed to practice medicine in all its branches or a certified athletic trainer working in conjunction with a physician licensed to practice medicine in all its branches 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. In accordance with state law, all IHSA member schools are required to follow this policy.

You should also inform your child's coach if you think that your child may have a concussion. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:
http://www.cdc.gov/ConcussionInYouthSports/

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 7/1/2011 Reviewed 4/24/2013, Reviewed 7/16/2015

IHSA Performance-Enhancing Substance Testing Policy

In 2008, the IHSA Board of Directors established the association's Performance-Enhancing Substance (PES) Testing Program. Any student who participates in an IHSA-approved or sanctioned athletic event is subject to PES testing. A full copy of the testing program and other related resources can be accessed on the IHSA Sports Medicine website. Additionally, links to the PES Policy and the association's Banned Drug classes are listed below. School administrators are able to access the necessary resources used for program implementation in the IHSA Schools Center.

IHSA PES Testing Program
http://www.ihsa.org/documents/sportsMedicine/2015-16/2015-16%20PES%20policy%20final.pdf

IHSA Banned Drug Classes
http://www.ihsa.org/documents/sportsMedicine/2015-16/2015-16%20IHSA%20Banned%20Drugs.pdf

insert Consent Language here (w/o signature lines)

IHSA Steroid Testing Policy Consent to Random Testing

As a prerequisite to participation in IHSA athletic activities, we agree that I/our student will not use performance-enhancing substances as defined in the IHSA Performance-Enhancing Substance Testing Program Protocol. We have reviewed the policy and understand that I/our student may be asked to submit to testing for the presence of performance-enhancing substances in my/our student's body either during IHSA state series events or during the school day, and I/our student do/does hereby agree to submit to such testing and analysis by a certified laboratory. We further understand and agree that the results of the performance-enhancing substance testing may be provided to certain individuals in my/our student's high school as specified in the IHSA Performance-Enhancing Substance Testing Program Protocol which is available on the IHSA website at www.IHSA.org. We understand and agree that the results of the performance-enhancing substance testing will be held confidential to the extent required by law. We understand that failure to provide accurate and truthful information could subject me/our student to penalties as determined by IHSA.

A complete list of the current IHSA Banned Substance Classes can be accessed at http://www.ihsa.org/documents/sportsMedicine/2015-16/2015-16%20IHSA%20Banned%20Drugs.pdf