State of Illinois

Certificate of Child Health Examination

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

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

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

ALLERGIES (Food, drug, insect, other)	☐ Yes ☐ No	List:	MEDICATION (Prescribed or taken on a regular basis)	☐ Yes ☐ No	List:

Diagnosis of Asthma?	☐ Yes ☐ No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	☐ Yes ☐ No	
Child wakes during night coughing?	☐ Yes ☐ No		Hospitalization? When? What for?	☐ Yes ☐ No	
Birth Defects?	☐ Yes ☐ No		Surgery? (List all) When? What for?	☐ Yes ☐ No	
Developmental delay?	☐ Yes ☐ No		Serious injury or illness?	☐ Yes ☐ No	
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.	☐ Yes ☐ No		TB skin test positive (past/present)?	☐ Yes* ☐ No	*If yes, refer to local health department
Diabetes?	☐ Yes ☐ No		TB disease (past or present)?	☐ Yes* ☐ No	
Head injury/Concussion/Passed out?	☐ Yes ☐ No		Tobacco use (type, frequency)?	☐ Yes ☐ No	
Seizures? What are they like?	☐ Yes ☐ No		Alcohol/Drug use?	☐ Yes ☐ No	
Heart problem/Shortness of breath?	☐ Yes ☐ No		Family history of sudden death before age 50? (Cause?)	☐ Yes ☐ No	
Heart murmur/High blood pressure?	☐ Yes ☐ No				
Dizziness or chest pain with exercise?	☐ Yes ☐ No				

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

☐ Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other

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

Additional Information:

Ear/Hearing problems?	☐ Yes ☐ No	
Bone/Joint problem/injury/scoliosis?	☐ Yes ☐ No	

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

Parent/Guardian Signatures: _____ **Date:** _____

IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine/Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric DT (Check specific type)	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella						
Varicella (Chickenpox)						
Meningococcal Conjugate						
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments: * indicates invalid dose

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature _____ Title _____ Date _____

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

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

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

*MEASLES (Rubeola) (MO/DA/YR) _____ **MUMPS (MO/DA/YR) _____ HEPATITIS B (MO/DA/YR) _____ VARICELLA (MO/DA/YR) _____

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease _____ Signature _____ Title _____

3. Laboratory Evidence of Immunity (check one) ☐ Measles* ☐ Mumps** ☐ Rubella ☐ Varicella Attach copy of lab result.

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

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

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

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old _____ HEIGHT _____ WEIGHT _____ BMI _____ BMI PERCENTILE _____ B/P _____

DIABETES SCREENING: (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** ☐ Yes ☐ No And any two of the following: **Family History** ☐ Yes ☐ No

Ethnic Minority ☐ Yes ☐ No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) ☐ Yes ☐ No **At Risk** ☐ Yes ☐ No

LEAD RISK QUESTIONNAIRE: Required for children aged 6 months through 6 years enrolled in licensed or public-school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high-risk zip code.)

Questionnaire Administered? ☐ Yes ☐ No **Blood Test Indicated?** ☐ Yes ☐ No **Blood Test Date** _____ **Result** _____

TB SKIN OR BLOOD TEST: Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

☐ No test needed ☐ Test performed **Skin Test:** Date Read _____ Result: ☐ Positive ☐ Negative mm _____

Blood Test: Date Reported _____ Result: ☐ Positive ☐ Negative Value _____

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

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

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

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

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

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

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

☐ Yes ☐ No If yes, please describe:

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

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

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

Address Phone

ST LIBORY CUSD #30
811 Darmstadt Street
St. Libory, IL 62282
618-768-4923
Medication Policy

This form must be filled out and signed each school year by the child's parent/guardian and the child's authorized health care provider before the child can be assisted with the administration of medication by the school office. The following applies:

1. A signed and dated Medication Authorization from the parent/legal guardian must be on file in the student's health record.
2. Students who have a chronic health condition such as a seizure disorder, asthma, ADD/ADHD, or diabetes that require the routine administration of medication while attending school, must have a physician's order in addition to authorization from the parent/legal guardian on file in the student's health records.
3. Students must bring medication, prescription, or non-prescription, in the original container, which includes the students' name printed on the container.
4. Students are **not** to store medication in their lockers or keep medication on their person or in book bags or purses. Storage of **all** medication is to be in the main office.
5. The exception to the above are students who possess an epinephrine auto-injector and/or medication prescribed for asthma for immediate use at the students' discretion, provided the student's parent/guardian has completed and signed the parental permission form and a signed physician's order is on file in the student's health record.

When a student experiences unforeseen symptoms while attending school the use of over-the-counter medication may occur. The goal for the use of medication at these times is to assist the student to participate to their fullest by relieving symptoms and remaining in school. Ibuprofen and acetaminophen are used to relieve minor pain associated with menstrual cramps, minor headaches not associated with injury, toothache or pain due to orthodontic appliances; throat lozenges to relieve minor cough and sore throat, and antacids for minor indigestion or upset stomach. By signing this policy you are authorizing that these medications may be administered to the student at the school's discretion.

TO BE COMPLETED BY PARENT/GUARDIAN: I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize St. Libory School and its employees, on my behalf to administer or to allow my child to self-administer, while under the supervision of the employees of St. Libory School District, according to the prescription/dosage instructions.

I UNDERSTAND AND AGREE TO:

1. Assume responsibility for getting my child's medication in its original prescription container, supplies, and equipment to the school office.
2. Inform the St. Libory School in writing of any important information or special instructions related to the administration of medication to my child.
3. Medicine will not be sent home on a daily basis.
4. Pick up medication at the end of the school year.

Parent Permission For Student To Take Over the Counter and/or Prescription Medication:

Student's Name_____ **Age**_____ **Weight**_____

Parent's Work/Cell Phone:_____ **Parent Email**_____

Parent/Guardian Signature_____ **Date**_____

Physician's Order For Prescription Medication To Be Administered During School Hours:

Diagnosis/Condition:_____

Medication/Dosage/Time to be Administered:_____

Possible Side Effects:_____

Duration of time medication is to be used:_____

Signature of Physician_____ **Date**_____

If a student is self-medicating (such as with an inhaler and/or epinephrine auto injector) please complete the following:

I certify that_____**has been instructed in the use and self-administration of** _____ **and that he/she is capable of using this medicine independently and understands the need for the medication and the necessity to report to school personnel and unusual side effects.**

Signature of Physician_____ **Date**_____

Print Name of Physician_____

Address_____ **Phone**_____

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**_____

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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.

IHSA Steroid Testing Policy Consent to Random Testing

(This section for high school students only)
2013-2014 school term

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/his/her 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/initiatives/sportsMedicine/files/IHSA_banned_substance_classes.pdf

Signature of student-athlete Date Signature of parent-guardian Date

IHSA Sports Medicine Acknowledgement & Consent Form

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. The Youth Sports Concussion Safety Act requires athletes to complete the Return to Play (RTP) protocols for their school 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.

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, 7/16/2015, July 2017

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 Substance Policy.

STUDENT

Student Name (Print): _____ Grade _____

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.