

Butte Falls School District #91

Authorization for Emergency Medical Treatment (grade _____)

As legal custodian of _____, a minor, I hereby authorize the principal or his/her designee, into whose care the aforementioned minor pupil has been entrusted, to initiate paramedic/ambulance care or transport for said minor and to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis, treatment, and /or hospital care to be rendered to said minor upon the advice of any licensed physician and/or dentist.

I understand that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary.

This authorization shall remain effective for the full year unless revoked in writing and delivered to said agent(s). I understand that the Butte Falls School District, its employees and its Board assume no liability of any nature in relation to the transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my responsibility.

I understand that the Butte Falls School District does not provide medical insurance for student injuries but does offer student accident/health insurance for voluntary purchase which was included in your registration packet.

PLEASE CHECK: ☐ I will allow a school employee to transport my student to the Butte Falls Community Health Center.

☐ I will not allow a school employee to transport my student to the Butte Falls Community Health Center.

Signature of Parent or guardian _____ Phone # _____ Date _____

Relative or friend with whom emergency arrangements have been made in case parents are not available: _____ Phone # _____

Family Doctor/Address and Phone # _____

Health Plan/Insurance: _____ Group/Policy Number _____

My child is allergic to the following medications and foods: _____

Other medications used: _____ other health problems: _____

(Signature of Parent/Guardian)

Phone #

Date

Butte Falls School District is an equal opportunity employer

BUTTE FALLS CHARTER SCHOOL
ATHLETIC PARTICIPATION PERMIT

Name: _____
(First) (Middle) (Last) (grade)

Last school attended: _____

Name of parent/guardian: _____ Phone: _____

Emergency Contact: _____
(Name) (Phone)

Physician: _____

Phone: _____

Address: _____

List any special medical instructions regarding your child:

*****PARENTAL/GUARDIAN PERMIT*****

I want my child to have the privilege of participating in competitive school athletics. My child _____ has my permission to compete in school sports approved by the Board of Directors and to go with the coach on any regularly scheduled trips. While I expect school authorities to exercise reasonable precautions to avoid injury. I understand that they assume **NO** financial obligation for any injury that may occur. I also authorize School District # 91 and its employees to secure the services of a licensed physician or hospital in the event of accident or illness if the parents/guardian are unable to be reached.

Please check any sport in which your child **MAY NOT** participate:

- ☐ Football ☐ Volleyball ☐ Basketball ☐ Track
☐ Baseball ☐ Softball ☐ Other

Students must be covered by some form on insurance prior to practicing and competing in any athletic activity. The school is **NOT** responsible for any medical cost that may occur. Please check one of the following:

- ☐ I desire that my child obtain the athletic insurance offered through the school
☐ My child is fully covered by insurance carried by his/her parent/guardian and the school **will not** be liable for any injury that occurs during athletic practices, contest, games, or during travel to and from events.

Name of Insurance Company: _____

Address of Company: _____

Policy #: _____

Signature of Parent/Guardian _____

_____ Date

Butte Falls School District is an equal opportunity employer

**WAIVER OF LIABILITY AND HOLD HARMLESS FOR COMMUNICABLE
DISEASES INCLUDING COVID-19**

Student Name: _____

Grade: _____ Home Phone: _____

Address: _____

Parent(s)/Guardian(s) Names: _____

Parent/ Guardian phone: Work: _____ Home: _____ Other: _____

The novel coronavirus ("COVID-19"), has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. While rules, guidance, and personal discipline may reduce this risk, the risk of serious illness and death does exist. **[Name School District] ("District") cannot completely mitigate the transfer of communicable diseases like COVID-19 especially when involved in [sport or activity]. Participation in [sport or activity] includes possible exposure to and illness, injury, or death from infectious diseases including COVID-19.**

In consideration for providing my child the opportunity to participate in [sport or activity] and any related transportation to and from [sport or activity] events, both my child and I voluntarily agree to waive and discharge any and all claims against District and release it from liability for any exposure to or illness or injury from an infectious disease including COVID-19, including claims for any negligent actions of the District or its employees or agents, to the fullest extent allowed by law, for myself, my child, our estates, our heirs, our administrators, our executors, our assignees, and our successors.

I also agree to release, exonerate, discharge and hold harmless the District, its Board of Directors, the individual members thereof, and all officers, agents, employees, volunteers, and representatives from all liability, claims, causes of action, or demands, including attorney fees, fines, fees, or other costs (e.g. medical costs) arising out of any exposure to or illness or injury from an infectious disease including COVID-19, which may result from or in connection with my child's participation in [sport or activity]

I further certify and represent that I have the legal authority to waive, discharge, release, and hold harmless the released parties on behalf of myself and the above-named student.

I also understand and agree that in consideration for participating in any sports or activities and any related transportation to and from events, Student is committed and agrees to isolate and quarantine if exposed to COVID-19.

I certify that I have read this document in its entirety and fully understand its contents. In exchange for the opportunity to participate in the [sport or activity], the above-named student and I freely and voluntarily assume all risks of such hazards and notwithstanding such, release District from all liability for any loss regardless of cause, and claims arising from the student's participation in the [sport or activity].

Student Signature

Date

Parent/Legal Guardian Signature

Date

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the provider. The provider should keep this form in the medical record.)

Date of Exam: _____

Name: _____

Date of birth: _____

Sex: _____ Age: _____ Grade: _____ School: _____

Sport(s): _____

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

☐ Foods

☐ Stinging Insects

Explain “Yes” answers below. Circle questions you do not know the answers to.

GENERAL QUESTIONS		
1. When was the student’s last complete physical or “checkup?” Date: Month/ Year ____/____ (Ideally, every 12 months)	YES	NO
2. Has a doctor or other health professional ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical conditions? If so, please identify below.		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU		
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, or get tired more quickly than your friends or classmates during exercise?		
11. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
12. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
13. Does anyone in your family have a pacemaker, an implanted defibrillator, or heart problems like hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?		

BONE AND JOINT QUESTIONS	YES	NO
14. Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice, game or an event?		
15. Do you have a bone, muscle or joint problem that bothers you?		
MEDICAL QUESTIONS		
16. Do you cough, wheeze or have difficulty breathing during or after exercise?		
17. Have you ever used an inhaler or taken asthma medicine?		
18. Are you missing a kidney, an eye, a testicle (males), your spleen or any other organ?		
19. Do you have any rashes, pressure sores, or other skin problems such as herpes or MRSA skin infection?		
20. Have you ever had a head injury or concussion?		
21. Have you ever had numbness, tingling, or weakness, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or someone in your family have sickle cell trait or disease?		
24. Have you, or do you have any problems with your eyes or vision?		
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of food?		
28. Have you ever had an eating disorder?		
29. Do you have any concerns that you would like to discuss today?		
FEMALES ONLY		
30. Have you ever had a menstrual period?		
31. How old were you when you had your first menstrual period? _____		
32. 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 _____

ORS 336.479, Section 1 (3) "A school district shall require students who continue to participate in extracurricular sports in grades 7 through 12 to have a physical examination once every two years." Section 1(5) "Any physical examination required by this section shall be conducted by a (a) physician possessing an unrestricted license to practice medicine; (b) licensed naturopathic physician; (c) licensed physician assistant; (d) certified nurse practitioner; or a (e) licensed chiropractic physician who has clinical training and experience in detecting cardiopulmonary diseases and defects."

Form adapted from ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

PHYSICAL EXAMINATION FORM

Date of Exam: _____

Name: _____

Date of birth: _____

Sex: _____ Age: _____ Grade: _____ School: _____

Sport(s): _____

EXAMINATION		
Height:	Weight:	BMI:
BP: / (/)	Pulse:	Vision R 20/ L 20/ Corrected <input type="checkbox"/> YES <input type="checkbox"/> NO
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart •Murmurs (auscultation standing, supine, with and without Valsalva)		
Pulses		
Lungs		
Abdomen		
Skin		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		

☐ Cleared for all sports without restriction☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for:☐ Not cleared☐ Pending further evaluation☐ For any sports☐ For certain sports: _____

Reason: _____

Recommendations: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians). This form is an exact duplicate of the current form required by the State Board of Education containing the same history questions and physical examination findings. I have also reviewed the "Suggested Exam Protocol".

Name of provider (print/type): _____

Date: _____

Address: _____

Phone: _____

Signature of provider: _____

ORS 336.479, Section 1 (3) "A school district shall require students who continue to participate in extracurricular sports in grades 7 through 12 to have a physical examination once every two years." Section 1(5) "Any physical examination required by this section shall be conducted by a (a) physician possessing an unrestricted license to practice medicine; (b) licensed naturopathic physician; (c) licensed physician assistant; (d) certified nurse practitioner; or a (e) licensed chiropractic physician who has clinical training and experience in detecting cardiopulmonary diseases and defects."

Form adapted from ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

MUSCULOSKELETAL

Have patient:

1. Stand facing examiner
2. Look at ceiling, floor, over shoulders, touch ears to shoulders
3. Shrug shoulders (against resistance)
4. Abduct shoulders 90 degrees, hold against resistance
5. Externally rotate arms fully
6. Flex and extend elbows
7. Arms at sides, elbows 90 degrees flexed, pronate/supinate wrists
8. Spread fingers, make fist
9. Contract quadriceps, relax quadriceps
10. "Duck walk" 4 steps away from examiner
11. Stand with back to examiner
12. Knees straight, touch toes
13. Rise up on heels, then toes

To check for:

- AC joints, general habitus
- Cervical spine motion
- Trapezius strength
- Deltoid strength
- Shoulder motion
- Elbow motion
- Elbow and wrist motion
- Hand and finger motion, deformities
- Symmetry and knee/ankle effusion
- Hip, knee and ankle motion
- Shoulder symmetry, scoliosis
- Scoliosis, hip motion, hamstrings
- Calf symmetry, leg strength

MURMUR EVALUATION – Auscultation should be performed sitting, supine and squatting in a quiet room using the diaphragm and bell of a stethoscope.

Auscultation finding of:

1. S1 heard easily; not holosystolic, soft, low-pitched
 2. Normal S2
 3. No ejection or mid-systolic click
 4. Continuous diastolic murmur absent
 5. No early diastolic murmur
 6. Normal femoral pulses
- (Equivalent to brachial pulses in strength and arrival)

Rules out:

- VSD and mitral regurgitation
- Tetralogy, ASD and pulmonary hypertension
- Aortic stenosis and pulmonary stenosis
- Patent ductus arteriosus
- Aortic insufficiency
- Coarctation

MARFAN'S SCREEN – Screen all men over 6'0" and all women over 5'10" in height with echocardiogram and slit lamp exam when any two of the following are found:

1. Family history of Marfan's syndrome (this finding alone should prompt further investigation)
2. Cardiac murmur or mid-systolic click
3. Kyphoscoliosis
4. Anterior thoracic deformity
5. Arm span greater than height
6. Upper to lower body ratio more than 1 standard deviation below mean
7. Myopia
8. Ectopic lens

CONCUSSION -- When can an athlete return to play after a concussion?

After suffering a concussion, no athlete should return to play or practice on the same day. Previously, athletes were allowed to return to play if their symptoms resolved within 15 minutes of the injury. Studies have shown that the young brain does not recover that quickly, thus the Oregon Legislature has established a rule that no player shall return to play following a concussion on that same day and the athlete must be cleared by an appropriate health care professional before they are allowed to return to play or practice.

Once an athlete is cleared to return to play, they should proceed with activity in a stepwise fashion to allow their brain to readjust to exertion. The athlete may complete a new step each day. The return to play schedule should proceed as below following medical clearance:

Step 1: Light exercise, including walking or riding an exercise bike. No weightlifting.

Step 2: Running in the gym or on the field. No helmet or other equipment.

Step 3: Non-contact training drills in full equipment. Weight training can begin. Step 4: Full contact practice or training.

Step 5: Game play.

If symptoms occur at any step, the athlete should cease activity and be re-evaluated by a health care provider.

581-021-0041 Form and Protocol for Sports Physical Examinations

1. The State Board of Education adopts by reference the form entitled "School Sports Pre-Participation Examination " dated May, 2017 that must be used to document the physical examination and sets out the protocol for conducting the physical examination. The form may be used in either a hard copy or electronic format. Medical providers may use their electronic health records systems to produce the electronic form. Medical providers conducting physicals of students who participate in extracurricular activities in grades 7 through 12 must use the form.
2. The form must contain the following statement above the medical provider's signature line:
This form is an exact duplicate of the current form required by the State Board of Education containing the same history questions and physical examination findings. I have also reviewed the "Suggested Exam Protocol".
3. Medical providers conducting physicals on or after April 30, 2011 and prior to May 1, 2017 must use the form dated May 2010.
4. Medical providers conducting physicals on or after May 1, 2017 and prior to May 1, 2018 may use either the form dated May 2010 or the form dated May, 2017.
5. Medical providers conducting physicals on or after May 1, 2018 must use the form dated May, 2017.

NOTE: The form can be found on the Oregon School Activities Association (OSAA) website: <http://www.osaa.org>

Stat. Auth.: ORS 326.051 Stats.

Implemented: ORS 336.479