

**Greater Albany SD 8J
Administrative Regulation**

Code: **JFBA-AR(3)**
Adopted: 3/79
Revised/Readopted: 4/79; 6/79; 10/80;
6/93; 3/12/01;
8/13/07
Orig. Code(s): AR 5503, AR 5504,
AR 5506, AR 5505,
AR 5502

Medical and Legal Procedures for Athletic Participation

1. Physical Examinations

- a. Students in grade nine must have a physical examination prior to participation in athletic activities performed by a physician licensed by the Oregon State Board of Medical Examiners, or a physician's assistant, nurse practitioner, registered nurse or community health nurse specifically trained for this purpose, under the supervision of a physician. The examination should be performed no earlier than May 1 of the preceding school year.
- b. Students who are in the tenth, eleventh and twelfth grade who have on file a physical examination from the preceding school year do not need an additional exam.
- c. In addition, physical examinations shall be given:
 - (1) When a student is new to the district and/or has not had the required Oregon Medical Examination or its equivalent;
 - (2) When the student has undergone major surgery in the intervening period between scheduled examinations;
 - (3) After accident or injury, a Return to Participation form must be completed.
- d. Annual physical examinations are required in the following situations:
 - (1) When the student has been given a diagnosis of a significant disease process or illness;
 - (2) When the student has an ongoing significant disease process or chronic illness;
 - (3) Significant disease processes or illnesses include, but are not limited to:
 - (a) Epilepsy;
 - (b) Asthma;
 - (c) Diabetes;
 - (d) Chronic heart disease including heart murmur;
 - (e) Severe allergy.
- e. All students participating in extramurals (participation not more than three times a week) will not need a physical examination to practice and compete.

2. Athletic Participation Permit

- a. All participants in interscholastic sports must have on file with the athletic coordinator an Athletic Participation Permit signed by the parent(s)/guardian(s)¹.
- b. All participants in extramural sports must have on file with their respective athletic coordinator an Extramural Activity Parent Consent form signed by the parent/guardian indicating that the student has permission to participate.

3. Conditioning and Training

All participants must have an appropriate period of training and physical conditioning prior to engaging in a contest. This period of time shall be determined by district personnel and will depend on the physical condition of the athlete and the type of competition.

4. Medical Protocol

A medical protocol pertaining to, but not limited to, gymnastics, football, basketball, baseball and wrestling contests shall be written and kept in the principal's office and distributed to each coach.

- a. Available doctor Name _____ Phone _____
- b. Designates person who will be in charge of implementing the protocol (coach on duty).
- c. Designated vehicle which accommodates a stretcher for transportation of the injured.
- d. Stretcher.
- e. First-aid kit.
- f. Location of the nearest available telephone.
- g. Location of the nearest available medical facility.
- h. Location of school health records of the participant.
- i. Notifying the parent/guardian of injured student.

5. The appropriate forms and materials to meet the requirements of this administrative rules are available in each middle school and high school in the district.

¹As used in this document, the term parent includes legal guardian or person in a parental relationship. The status and duties of a legal guardian are defined in ORS 125.005 (4) and 125.300-125.325. The determination of whether an individual is acting in a parental relationship, for purposes of determining residency, depends on the evaluation of the factors listed in ORS 419B.373. The determination for other purposes depends on evaluation of those factors and a power of attorney executed pursuant to ORS 109.056. For special education students, parent also includes a surrogate parent, an adult student to whom rights have transferred and foster parent as defined in OAR 581-015-0005(18).

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(continued)

Medical Report For Students (Grade 9-12)

TO BE FILLED IN BY PARENT/GUARDIAN BEFORE PHYSICAL EXAMINATION: (Please Print)

School to be Attending _____ Grade _____
 Student's Name _____ Sex: M F Birth _____
 Last _____ First _____ Mo. _____ Day _____ Yr. _____
 Address _____ Phone _____
 State or Rural Route _____ Town _____

Check the following information about your child:

1. Past Concussions	Yes*	No	Yr	8. Diabetes	Yes*	No	Yr	14. Allergies:	Yes*	No	Yr
Past skull fractures	Yes*	No	Yr	9. Rheumatic Fever	Yes*	No	Yr	Asthma Insects/Bee Sting	Yes*	No	Yr
2. Neck Injury	Yes*	No	Yr	10. Kidney Disease	Yes*	No	Yr	Hay Fever	Yes*	No	Yr
3. History of muscle, bone or joint disease	Yes*	No	Yr	11. Fainting Spells	Yes*	No	Yr	Poison Oak	Yes*	No	Yr
4. Glasses or contact lenses for athletics	Yes*	No	Yr	12. Epilepsy or other convulsive disorders or seizures	Yes*	No	Yr	Other	Yes*	No	Yr
Loss or seriously impaired vision in one eye?	Yes*	No	Yr	13. Communicable Diseases:	Yes*	No	Yr	15. Tonsils Adenoids removed	Yes*	No	Yr
5. Hearing Problem	Yes*	No	Yr	German Measles (3)	Yes*	No	Yr	16. Currently taking medication or shots	Yes*	No	Yr
6. Pneumonia	Yes*	No	Yr	Red Measles	Yes*	No	Yr	17. Premature Birth	Yes*	No	Yr
7. Hernia	Yes*	No	Yr	Mumps	Yes*	No	Yr	18. Any other serious defects or operations	Yes*	No	Yr
				Chickenpox	Yes*	No	Yr				
				Whooping Cough	Yes*	No	Yr				
				Scarlet Fever	Yes*	No	Yr				
				OTHER	Yes*	No	Yr				

Parent's or Guardian's Comment on "Yes" _____

Immunization Summary

	Initial Series	1 st Booster	Booster	Given Today	TESTS	Results	Given Today
Diphtheria	19__	19__	19__	_____	Tuberculin	19__	_____
Whooping Cough	19__	19__	19__	_____	Chest X-ray	19__	_____
Tetanus	19__	19__	19__	_____	Other Test	19__	_____
Smallpox	19__	19__	19__	_____	Measles (Vaccine)	19__	_____
Polio	19__	19__	19__	_____	Mumps (Vaccine)	19__	_____
Sabin-Oral	19__	19__	19__	_____	Rubella (Vaccine)	19__	_____

Parent's or Guardian's comments regarding behavior and any physical or emotional problems: _____

Doctor's Physical Examination

Height _____ Blood Pressure _____ Vision with glasses R 20/ _____ L 20/ _____
 Weight _____ Vision without glasses

Significant Illnesses or Injuries _____

Examination	Satisfactory	Unsatisfactory	Examination	Satisfactory	Unsatisfactory
Teeth	_____	_____	Extremities	_____	_____
Hearing	_____	_____	Orthopedic/Posture	_____	_____
Cardiovascular	_____	_____	Neurological	_____	_____
Respiratory	_____	_____	Skin	_____	_____
Liver, spleen, kidney, hernia, genitals	_____	_____	Indicated Lab Tests	_____	_____
			Urinalysis negative for sugar	_____	_____

Comments on unsatisfactory conditions _____

I have on this date examined the above student and recommend him/her as being physically able to participate in regularly scheduled physical education classes and compete in the supervised athletics NOT CIRCLED: BASEBALL, BASKETBALL, CROSS COUNTRY, FIELD HOCKEY, FOOTBALL, GOLF, GYMNASTICS, SKIING, SOCCER, SOFTBALL, SPEED-A-WAY, SWIMMING, TENNIS, TRACK, VOLLEYBALL, WRESTLING*, OTHER _____

*This boy may be permitted weight loss to make a lower weight class in Wrestling. Yes _____ No _____ If "yes," may lose _____ pounds. (grades 9-12)

Date _____ Signature of Examining Physician _____

Note-Physician is licensed by the Oregon State Board of Medical Examiners

Return to Participation Form

TO BE COMPLETED BY STUDENT:

Name _____ School _____

Home Address _____ Phone _____

Grade _____ Birthdate _____

Parent's or Guardian's Name _____

Injury (illness) Information:

Time and Date of injury _____

Injured in practice _____ Game _____ Other _____

Activity/Sport _____ Position Played _____

Inst./Coach _____ Phone _____

Description of Injury:

TO BE COMPLETED BY PHYSICIAN:

Diagnosis: _____

Recommendations:

- No restrictions (discharged) as of _____ Date _____

- No practice or play until _____ Date _____

- Expected return to activity. Definite date after further evaluation _____ Date _____

- Light running ONLY - NO Contact _____

- Regular Practice, but NO Contact _____

- Return for further care - No _____ Yes _____

- Other _____

Physician _____

Phone _____

Date _____

