District School Board of Niagara

ADMINISTRATIVE PROCEDURE

SECTION:	GENERAL SCHOOL OPERATIONS	A.P. NO.:	**1-14**
TOPIC:	**PERMISSION TO PARTICIPATE IN CURRICULAR (PHYSICAL EDUCATION) AND EXTRA-CURRICULAR ATHLETIC PROGRAMS**	PAGE:	Page 1 of 1
		DATE:	June 2011
REVIEW DATE:	June 2016	REVISED:	April 2013

Physical activity is essential for normal, healthy growth and development. Growing bones and muscles require not only good nutrition, but also the stimulation of vigorous physical activity to increase the strength and endurance necessary for a physically active lifestyle. Active participation in curricular (physical education) classes, which includes games, dance, gymnastics, and outdoor pursuits, provides opportunities for students to develop the skills and confidence necessary to play and work co-operatively and competitively with their peers.

Students participating in the curricular (physical education) athletic program and any extra-curricular athletic programs must complete a *Permission to Participate Form* (see Appendix A or Appendix B). These forms include~~s~~ medical and personal information needed by a coach/staff member in case of an emergency.

The DSBN Curricular (Physical Education) Athletic Program Permission to Participate Form (Appendix A) must be completed annually in September and whenever there are any health changes to a student prohibiting or altering their participation in athletic programs. This form (Appendix A) must be completed for every student of the DSBN participating in curricular (physical education) athletic programs.

The DSBN Extra-Curricular Athletic Program Permission to Participate Form (Appendix B) needs to be completed for each student **for each sport** in which they participate, however, if a student participates in more than one sport, parents/guardians need only complete the medical information section once per year unless medical conditions change.

Due to the confidential nature, completed forms shall be stored in the main office and shall be readily accessible by the coach at all times, including during practices and games.

Attachments

Appendix A: DSBN Curricular (Physical Education) Athletic Program – Permission to Participate Form
Appendix B: DSBN Extra-Curricular Athletic Program - Permission to Participate Form
Appendix C: Emergency Action Plan for Students with Anaphylaxis
Appendix D: Request to Resume Athletic Participation: Concussion Related Injuries

References

Policy D-4: Elementary Interschool Athletic Program
Administrative Procedure 1-13: Elementary Interschool Athletic Association
Administrative Procedures 3-27: Concussions

DSBN CURRICULAR (PHYSICAL EDUCATION) ATHLETIC PROGRAM

PERMISSION TO PARTICIPATE FORM

Name of School _____

Name of Student _____ Grade _____

1. Please indicate if your child/ward has been subject to any of the following and provide pertinent details:
   - epilepsy, diabetes, orthopaedic problems, heart disorders, asthma, allergies:

     Yes ☐ No ☐ If yes, please describe _____

     _____
   - head or back conditions or injuries (in the past two years):

     Yes ☐ No ☐ If yes, please describe _____

     _____
   - arthritis or rheumatism; chronic nosebleeds; dizziness; fainting; headaches; dislocated shoulder, hernia; swollen, hyper-mobile or painful joints; trick or lock knee:

     Yes ☐ No ☐ If yes, please describe _____

     _____
2. What medication(s) should your child/ward have on hand during the physical activity?

   _____

   Who should administer the medication? _____
3. Has your child/ward been identified as anaphylactic? Yes ☐ No ☐
   - If yes, does he/she carry an epinephrine auto injector (e.g., EpiPen)? Yes ☐ No ☐
4. Does your child/ward wear a medical alert bracelet, medical chain or medical alert card? Yes ☐ No ☐
   - If yes, please specify what is written on it: _____
5. Does your child/ward have any other diagnosed medical condition that will require modification to the program?

   _____
6. If a concussion has been diagnosed over the summer break, the Request to Resume Athletic Participation - Concussion Related Injuries form must be completed by a physician before the student returns to class/intramural and interschool activities. See Appendix D.

ELEMENTS OF RISK NOTICE **The risk of injury exists in every athletic activity. However, due to the very nature of some activities, the risk of injury may increase. Injuries may range from minor sprains and strains to more serious injuries. These injuries result from the nature of the activity and can occur without fault on either the part of the student, the school board or its employees/agents or the facility where the activity is taking place. Some activities that are identified as having the potential for more serious consequences are: alpine skiing, snowboarding, snowsports, broomball (ice), cheerleading (acrobatic), field hockey, field lacrosse, gymnastics, ice hockey, ringette (ice), swimming, wrestling, and/or field events: high jump, shot put. The safety and well-being of students is a prime concern and attempts are made to manage, as effectively as possible, the foreseeable risks inherent in physical activity.**

I acknowledge and have read the Elements of Risk Notice. Yes ☐

I give permission for my child/ward _____to participate in the curricular athletic program.

Parent/Guardian Signature: _____ **Date:** _____

PLEASE NOTE: FREEDOM OF INFORMATION - The information provided on this form is collected pursuant to the District School Board of Niagara responsibilities as set out in the Education Act and its regulations. This information is protected under the Freedom of Information and Protection of Privacy Act and will be utilized only for the purposes related to Risk Management. Any questions with respect to this information should be directed to your school principal.

DSBN EXTRA-CURRICULAR ATHLETIC PROGRAM

PERMISSION TO PARTICIPATE FORM

This form is to be completed on behalf of an athlete who wishes to participate in extra-curricular athletic programs and must be returned to the coach/staff member after being selected by the coach/staff to participate in the athletic activity (after tryouts).
It is the responsibility of the in-school coach/advisor to keep an outside coach informed of the information on this form.

School: _____

Student's Name: _____

Athletic Activity: _____

A *Permission to Participate Form* must be completed for every athletic activity.

Have you completed a *Permission to Participate Form* for this student already this school year?

☐ Yes → *{**If the medical condition of your son/daughter is unchanged**, please skip the medical information section of this form and proceed to the 4th page for signed consent.}*

☐ No → *{Please complete all sections of this form.}*

TO THE PARENT/GUARDIAN

Your child/ward has chosen to participate and/or tryout in our DSBN Extra-curricular Athletic Program. This may involve vigorous physical activity.

In case of an injury, most basic Medical Plans do not provide coverage of permanent teeth or private nurses. If you wish this coverage, it is recommended that you investigate an Accident Policy.

GENERAL INFORMATION

Home Address: _____ Postal Code: _____

Home Telephone No.: _____

Parent/Guardian: _____ Work Telephone No.: _____

Cell Telephone No.: _____

Parent/Guardian: _____ Work Telephone No.: _____

Cell Telephone No.: _____

Student's Physician: _____ Telephone No.: _____

Emergency Contact: _____ Telephone No.: _____

Continued on Reverse → → →

MEDICAL INFORMATION

1. Date of last complete medical examination *{An annual medical examination is recommended}*: _____
2. Date of last tetanus immunization: _____
3. Is your child/ward allergic to any drugs, food/medication/other? ☐ Yes ☐ No

   If yes, provide details: _____

   _____
4. Does your child/ward take any prescription drugs? ☐ Yes ☐ No

   If yes, provide details: _____

   _____
5. What medication(s) should the participant have available during the sport activity?

   Provide details: _____

   _____
6. Who should administer the medication? _____
7. Does your child/ward wear: ☐ a medical alert bracelet ☐ neck chain ☐ carry a medical alert card?

   If Yes, specify what is written on it: _____
8. Has your child/ward been identified as being anaphylactic? ☐ Yes ☐ No

   If yes, does he/she carry an EpiPen? ☐ Yes ☐ No

   Have you completed the Emergency Action Plan for Students with Anaphylaxis (Appendix C).
9. Does your child/ward wear eyeglasses during athletic activities?

   ☐ Yes ☐ No Contact lenses? ☐ Yes ☐ No

Continued on Next Page → → →

MEDICAL INFORMATION (cont'd)

10. Please indicate whether your child/ward has been subject to any of the following and provide pertinent details:

- ☐ Epilepsy: _____
- ☐ Diabetes: _____
- ☐ Orthopaedic problems: _____
- ☐ Deaf/Hard of Hearing: _____
- ☐ Wheezing/Asthma: _____
- ☐ Allergies: _____
- ☐ Back or spinal cord conditions or injuries (in the past two years): _____
- ☐ Head conditions or injuries (in the past two years): _____
- ☐ Swollen or hyper-mobile or painful joints, trick or lock knee: _____
- ☐ Arthritis or Rheumatism: _____
- ☐ Chronic Nosebleeds: _____
- ☐ Skin/Kidney/Intestinal Problems: _____
- ☐ Hepatitis/Mononucleosis: _____
- ☐ Severe Allergic Reaction: _____
- ☐ Serious Illness/Injury: _____
- ☐ Previous Surgery (include date): _____
- ☐ Headaches/Concussions: _____
- ☐ Dizziness/Seizures/Fainting: _____
- ☐ Vision Impairment: _____
- ☐ Joint Conditions/Injuries: _____
- ☐ Heart Conditions/Injuries (give details): _____

_____

11. Please indicate any other medical condition that will limit participation:

_____

12. If a concussion has been diagnosed throughout the year, the Request to Resume Participation – Concussion Related Injuries form must be completed by a physician before the student returns to class, curricular (physical education) or extra-curricular athletic programs, attached as Appendix D.

Continued on Reverse → → →

Medical Services Authorization (optional)

In a situation when emergency medical or hospital services are required by the above listed participant, and with the understanding that every reasonable effort will be made by the school/hospital to contact me, my signature on this form authorizes medical and/or hospital to administer medical and/or surgical services, including an aesthesia and drugs. I understand that any cost will be my responsibility.

Signature of Parent/Guardian_____ Date_____

Athlete Accident Insurance Notice

The District School Board of Niagara does not provide any accidental death, disability, dismemberment/medical/dental insurance on behalf of the students participating in the activity. For coverage of injuries, you are encouraged to consider the Student Accident Insurance Plan made available by the school to parents at the beginning of, and throughout, the school year.

Transportation Insurance Notice

Please review your current vehicle insurance policy for insurance coverage.

Elements of Risk Notice (please refer to http://Safety.OPHEA.net for further information)

ELEMENTS OF RISK NOTICE **The risk of injury exists in every athletic activity. However, due to the very nature of some activities, the risk of injury may increase. Injuries may range from minor sprains and strains to more serious injuries. These injuries result from the nature of the activity and can occur without fault on either the part of the student, the school board or its employees/agents or the facility where the activity is taking place. Some activities that are identified as having the potential for more serious consequences are: alpine skiing, snowboarding, snowsports, broomball (ice), cheerleading (acrobatic), field hockey, field lacrosse, gymnastics, ice hockey, ringette (ice), swimming, wrestling, and/or field events: high jump, shot put. The safety and well-being of students is a prime concern and attempts are made to manage, as effectively as possible, the foreseeable risks inherent in physical activity.**

PARENT/GUARDIAN SIGNATURE	**Acknowledgement of Risks/Request to Participate/ Informed Consent Agreement**

I/We have read and understand the notice of Athlete Accident Insurance. ___ (initials of parent/guardian)

I/We have read and understand the notice of Elements of Risk. ___ (initials of parent/guardian)

I/We hereby acknowledge and accept the risk inherent in the requested activity, and assume responsibility for my/our child/ward for personal health, medical, dental and accident insurance coverage.

Parent/Guardian Name (please print):

_____

Parent/Guardian Signature: _____Date: _____

Freedom of Information Notice

The information provided on this form is collected pursuant to the Board's education responsibilities as set out in the Education Act and its regulations. This information is protected under the Freedom of Information and Protection of Privacy Act and will be utilized only for the purposes related to the Board's policy on Risk Management for Interschool Athletics. Any questions with respect to this information should be directed to your school principal.

Copied from APPENDIX A (A.P. 3-13)

EMERGENCY ACTION PLAN FOR STUDENTS WITH ANAPHYLAXIS

For Use Where Applicable (e.g. in: Classroom, Lunchroom, Staff Room, Office, Out of School Programs)

Name: _____

Allergen(s): _____

ALLERGY DESCRIPTION

This child has a DANGEROUS, life threatening allergy to the following:

_____

_____

_____

Place Student's Photo Here

(to be provided by parent)

RESTRICTIONS

List restrictions for this student, if any: _____

_____

_____

POSSIBLE SYMPTOMS (order may vary)

- flushed face, hives, swelling or itchy lips, tongue, eyes
- tightness in throat, mouth, chest
- difficulty breathing or swallowing, wheezing, coughing, choking
- vomiting, nausea, diarrhea, stomach pains
- dizziness, unsteadiness, sudden fatigue, rapid heartbeat
- loss of consciousness

EMERGENCY ACTION PLAN

Principals must fill out an O.S.B.I.E. incident form any time a student is taken by ambulance to a hospital as the result of an anaphylactic reaction.

NOTE: **Epinephrine auto-injector (e.g.** EpiPen®**)** are kept: _____
Expiry Date:_____

KNOW WHAT TO DO: The first signs of reaction can be mild but symptoms can get much worse quickly.

- **Use epinephrine auto-injector (e.g. Epipen®) immediately.**
- **Call 911 and advise the dispatcher that a child is having an anaphylactic reaction.**
- **If ambulance has not arrived in 10-15 minutes and breathing difficulties are present, give a second epinephrine auto-injector (e.g. Epipen®), if available.**
- **Even if symptoms subside entirely, this child must be taken by ambulance to the hospital.**

Signature of Doctor: _____ Date: _____

Signature of Parent: _____ Date: _____

Signature of Principal: _____ Date: _____

Permission to Post (where applicable) ☐ **Yes** ☐ **No**

Copied from APPENDIX G (A.P. 3-27)

REQUEST TO RESUME ATHLETIC PARTICIPATION: CONCUSSION RELATED INJURIES

If an athlete has been/is suspected of having a concussion, a physician must sign this form.

Athlete's Name: _____

The athlete must complete the following 2 visits with the physician and follow physician's instructions below:

Physician Visit #1

No concussion – athlete may return to:

- ☐ regular physical education class activities
- ☐ intramural activities/clubs
- ☐ interschool sport activities

Physician Name: _____ **Date:** _____

Physician signature: _____

Comments:

_____

_____

_____

OR

- ☐ **Concussion - no physical activity until symptoms and signs have gone**

Physician Name: _____ **Date:** _____

Physician signature: _____

Comments:

_____

_____

_____

Copied from APPENDIX G (A.P. 3-27)

Note: The athlete/parent/guardian must provide this form to the school administrator/designate who will inform all relevant personnel (teacher of Health and Physical Education, coach of interschool team, intramural supervisor, etc.) whether the athlete can participate in all activities OR a concussion has been diagnosed and no physical activity is permitted until signs and symptoms have gone.

When a concussion is diagnosed, the athlete and parents/guardians monitor symptoms and signs of a concussion throughout the Return to Physical Activity Process. As a part of this monitoring, ongoing communication must occur between the teacher and parent/guardian throughout Steps 1-4 of the Return to Physical Activity Process (6 Step Approach).

RETURN TO PHYSICAL ACTIVITY PROCESS (6 STEP APPROACH)

An athlete with a diagnosed concussion is to follow the medically supervised six step Return to Physical Activity Process below. All steps must be completed. The form "Sample Request to Resume Athletic Participation" (Appendix B-2) is to be used throughout the six step Return to Physical Activity Process to track the attainment of each step, including the necessary signatures by the physician, parent/guardian and teacher/coach.

The athlete may proceed to the next step only when he or she is asymptomatic at the current step.

Procedures:

- Steps are not days - each step must take a minimum of 24 hours.
- The length of time needed to complete each step will vary based on the severity of the concussion and on the student.
- If signs and symptoms return during any one of the steps the student must:
  - stop all physical activities immediately
  - rest for a minimum of 24 hours (i.e., physical and cognitive rest)
  - return to Step 1.

Parent/Guardian Responsibilities:

Step 1:

Rest: No activity, complete physical and cognitive rest. Duration: Until asymptomatic (minimum of 24 hours).

Step 2:

Activity: Individual activity only. Light aerobic exercise (e.g., walking or stationary cycling). Duration: Maximum of 10-15 minutes over a 24 hour period.

Restrictions: No resistance/weight training. No competition (including practices, scrimmages). No participation with equipment or with other students.

My signature below indicates that my son/daughter is symptom free after Steps 1 and 2 and I give permission for my son/daughter to proceed to Step 3 and participate in physical activities as described.

Parent/Guardian Name:_____ **Date**:_____

Parent/Guardian Signature:_____

Copied from APPENDIX G (A.P. 3-27)

School Responsibilities:

Step 3:

Activity: Individual activity only. Sport specific exercise (e.g., running drills, ball drills, shooting drills). Duration: Maximum of 20-30 minutes over a 24 hour period.

Restrictions: No resistance/weight training. No competition (including practices, scrimmages). No body contact, head impact activities (e.g., heading a ball in soccer), and other jarring motions (e.g., high speed stops, hitting a baseball with a bat).

Step 4:

Activity: Activities where there are minimal opportunities for body contact (e.g., dance, badminton, volleyball). Reviewing offensive and defensive plays at a slower speed. Light resistance/weight training.

Restrictions: No activities that involve body contact or head impact (e.g., "heading the ball" in soccer).

SCHOOL COMMUNICATION WITH PARENT/GUARDIAN:

The teacher's/coach's signature indicates that your son/daughter has successfully completed Steps 3 and 4 and now requires a physician's check-up prior to being permitted to engage in interschool activities.

Teacher/Coach Name: _____ **Date:** _____

Teacher/Coach signature:_____

Parent/Guardian Responsibility:

Note: After Step 4 and before Step 5 (return to full contact training/practice), the athlete must return to the physician for final approval to engage in interschool activities.

Physician Visit #2

Concussion symptoms and signs have gone – the athlete may return to:

- ☐ regular physical education class activities
- ☐ intramural activities/clubs
- ☐ interschool sport activities

Physician Name: _____ **Date:** _____

Physician signature:_____

Comments:

_____

_____

_____

Note: This form must be returned to the school administrator/designate who will inform all relevant personnel (teacher of Health and Physical Education, coach of interschool team, intramural supervisor, etc.) that the student can participate in all activities with no restrictions.

School Administrator/designate files the completed form "Sample Request to Resume Athletic Participation – Concussion Related Injuries" (Appendix B-2) from the doctor in athlete's O.S.R.

Step 5:

Activity: Full participation in regular physical education/intramural activities/interschool teams with no body contact. Full contact training/practices for interschool teams that involve body contact.

Restrictions: No competition (e.g., games, meets, events) that involve body contact.

Step 6:

Activity: Full participation in all physical activities, including full contact games.

Restrictions: None.