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A PROPOSAL FOR AN ATHLETIC TRAINING COOPERATIVE: ENHANCING SAFETY IN RURAL HIGH SCHOOLS

Professional Paper

Presented in Partial Fulfillment of the Requirement for the

DEGREE OF MASTER OF SCIENCE

Major in Health and Human Performance

to

THE UNIVERSITY OF MONTANA GRADUATE SCHOOL

by

John Curtis Weida

July 1995

Approved by:

Professor Sharon Dinkel Uhlig
Chair, Professional Paper

Dean, Graduate School

July 31, 1995

Date

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INTRODUCTION

Quality health care for participants of high school athletics, particularly athletes in rural areas is a legitimate concern. According to a study completed by the Health Education and Welfare Department, 6.4 million athletes participate in sports at the high school level each year. This same study found that over 1 million athletes are injured annually (Conley, 1982). Another study reported that there were 636,000 injuries annually in high school football alone (Powell, 1987). The Montana High School Association reports that Montana ranks 40th in the nation with 32,500 people who participate in high school athletics (MHSA personal communication, February 27,1995).

Numerous authors have stated the need for athletic trainers in high schools (Arnheim DD, 1987 Arnheim DD, Prentice WE, 1993, Richter ST, Burns CE, Fry CM, 1992, Emerick CE, Scharader JW, 1981). Arnheim and Prentice (1993) emphasized this by stating, "It would be ideal to have certified athletic trainers serve every secondary school in the United States. Many of the physical problems that occur later from improperly managed sports injuries could be avoided initially if proper care from an athletic trainer had been provided." Richter, Burns, and Fry (1992) stated, "The health and safety of our nation's young athletes should be our number one priority in interscholastic athletics. When we refuse to provide adequate medical care in a guaranteed accident-prone environment, for whatever reasons, we are acting irresponsibly." Yet some school administrators do not hire athletic trainers, and coaches, who are not

schooled in injury care, are left handling the needs of the injured athlete (Hage & Moore, 1981). In 1988 only 8.8% of Montana high schools employed or retained an athletic trainer (Solum, 1988).

The athletic trainer is a "highly qualified allied health professional, educated and experienced in dealing with the health care problems of athletes" (NATA, 1991). Since the formation of the National Athletic Trainers Association (NATA) in 1950, the athletic training profession has gone through some changes, one of which is the development of an athletic training curriculum. Since 1969, the NATA's Professional Education Committee (PEC) has approved athletic training education programs in colleges and universities in the United States (Curtis, 1993). The NATA approved undergraduate athletic training education program is designed to prepare qualified athletic trainers to work in high schools, junior colleges, four year colleges, professional sports organizations and other athletic health care facilities.

The University of Montana offers a Bachelor of Science degree in Health and Human Performance (HHP) with an emphasis in Athletic Training. This program meets the standards established by the NATA and is the only approved undergraduate curriculum in the state of Montana. The University of Montana graduates an average of six students per year that pass the certification exam (Murphy DT, 1995). There are 82 universities that offer a Bachelor's degree with an emphasis in athletic training. Over the past five years those schools graduated 3,452 students who became certified of which only 41% were able to find employment as an athletic trainer. Of that 41%, only 9% were hired by a high school. There are 13 schools

which offer a Master's degree in athletic training. Over the past five years those schools graduated 669 students and 87% were able to get an athletic training job. Of that 87% only 10% were hired by a high school (NATA PEC, 1994). Western Montana College and Montana State University also educate athletic trainers. The students who graduate from these schools become certified in athletic training through an internship program. Montana high schools and a cooperative could employ the students that graduate from all three of these Montana schools.

The ideal situation would be for each high school to have its own athletic trainer. Understanding that the ideal situation is not occurring, the idea of cooperative is proposed. An athletic training cooperative would provide high school athletes access to quality injury care, high school administrators low cost athletic trainers, and athletic trainers opportunity for full time employment. Cooperatives were initially developed to provide quality special education services to children in rural schools, but the cooperatives have expanded to provide rural schools with speech clinicians, psychologists, occupational therapists, physical therapists, counselors, and teachers. A cooperative is defined as groups of school districts which combine resources (funds, personnel, building space, etc.) to provide comprehensive services to handicapped children (McCurdy, 1988).

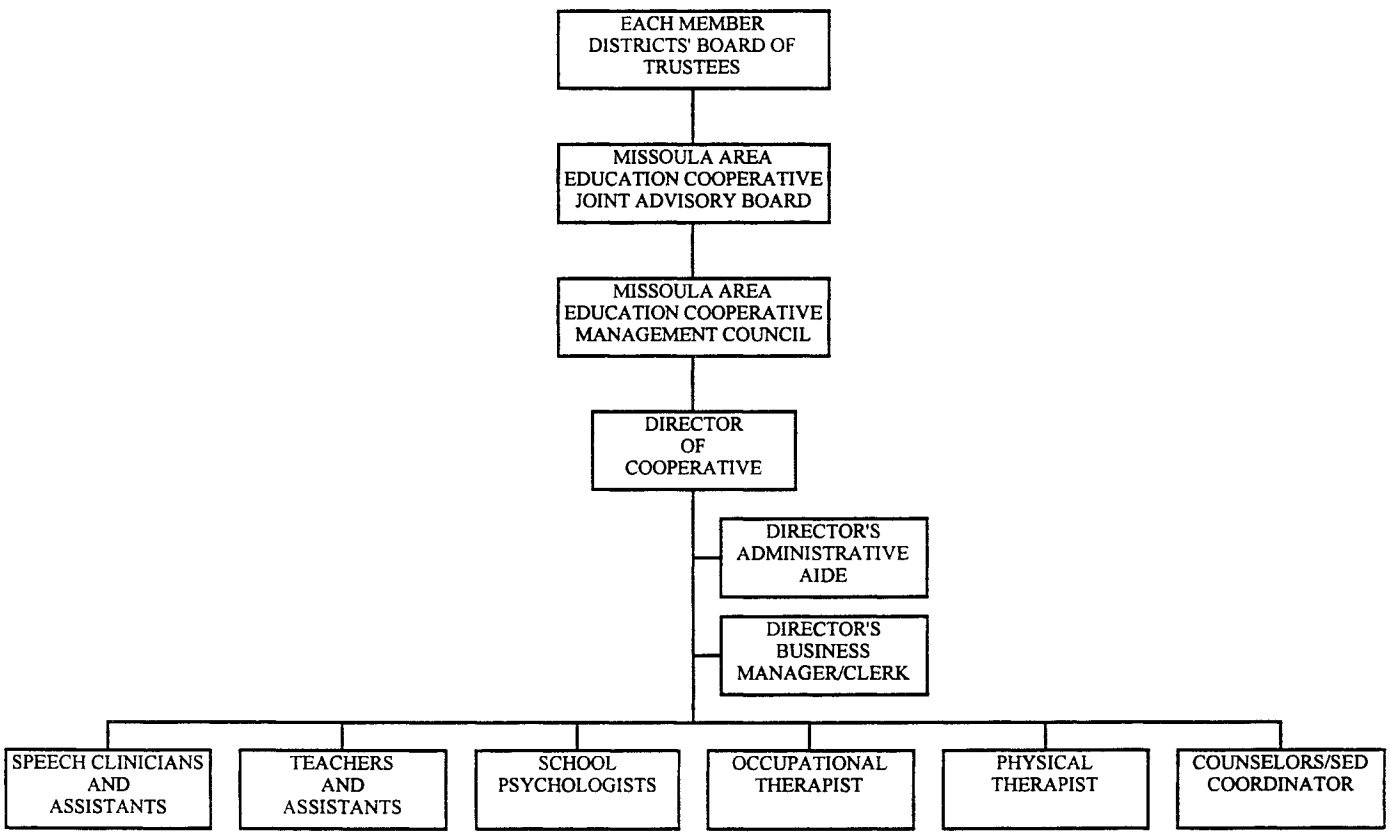
Cooperatives in Montana have a short history. In 1975 US. Public Law 94-142 mandated special education services for all handicapped children, and Montana state law 20-7-401 in 1977 required services to handicapped children and youth ages 5 through 18 years. This was a problem for Montana because of its large

geographic area and small population. The first idea for dealing with this problem was called the regional services program. This program, administered by the Office of Public Instruction, was comprised of five regions in Montana. The regional services program was found to be a limited means of service delivery, and regional services were terminated on June 30, 1980 (McCurdy, 1988).

Cooperatives arrived in October 1979, in the form of bill 20-7-451 (Appendix A) the "Full Service Special Education Cooperative" bill (Create full service education cooperative, 1993). This law was intended to assist districts too small to generate full-time special education teachers. With this bill, the cooperative could perform the duties the district was unable to perform due to limited funding. By July, 1981, twenty-nine special education cooperatives had been formed (McCurdy, 1988).

Fred Appelman, the director of the Missoula area cooperative, discussed the inner workings of a cooperative (personal communication, January 26, 1995). There are currently 23 cooperatives in the state of Montana and most schools are involved. The schools not involved are in the bigger districts. In the Missoula area cooperative, each district signs a contract for services and sends one representative from their Board of Trustees to serve on the Missoula Area Education Cooperative Joint Advisory Board. This advisory board, made up of 16 people from the Missoula area school districts, meets twice a year. This board chooses 5 people from the pool of 16 to be on the Missoula Area Education Cooperative Management Council (Figure 1). Those five people meet with the director of the cooperative once a month. The director of the

FIGURE 1
MISSOULA COOPERATIVE ADMINISTRATIVE CHART



cooperative handles the hiring and administrative duties involved with the cooperative teachers and workers. Most cooperatives around the state are managed in the same manner as the Missoula Area Cooperative. The management of the cooperative would not change by adding an athletic trainer.

The idea of a cooperative, or sharing an athletic trainer, has been considered before. In 1985 Phillip Hossler wrote an article on acquiring an athletic trainer at the high school level. Hossler listed eight options, from full time, to part time athletic trainers. One of the options that Hossler gives is similar to the idea of a cooperative. Hossler calls this option an athletic trainer rotation program. The example shows how two schools can share the services of an athletic trainer. This article also explains how the athletic trainer is paid and how a time schedule can be determined.

The athletic trainer is employed through a sports medicine clinic. The two schools, the clinic and the athletic trainer then determine a salary, which is divided evenly between the two schools. The health benefits for the athletic trainer are 25% of the agreed upon salary and are also divided between the two schools. The schools pay the clinic, which in turn pays the athletic trainer and provides the athletic trainers health care (Hossler 1985).

In Hossler's article, time schedules are discussed briefly. The article stressed that the two schools, the clinic, and the athletic trainer need to work out a schedule that everyone can agree upon. This can be done by having the athletic trainer work the morning in one school, and the afternoon in another school, or rotate schools every other day. The article also states that three schools could be

used for the rotation (Hossler 1985). It is important to remember that a sports medicine clinic is used as the cooperative in this example, otherwise the idea is the same as the one being proposed in this paper. In rural areas of Montana, a sports medicine clinic is not available for such use, but a cooperative may be a substitute.

The goal of this proposal is to provide the framework and rationale for incorporating athletic training into school districts through existing cooperatives or creating an athletic training cooperative between interested schools. This will be accomplished by:

1. Providing school administrators, coaches, and parents with an overview of an athletic trainer's role which includes prevention, evaluation and recognition of athletic injuries, record keeping, and teaching.

2. Providing schools with a blueprint for becoming a part of an existing cooperative or beginning an independent cooperative.

3. Detailing for school administrators, coaches, parents and athletes the schedule for covering practices and games.

4. Outlining for school administrators, coaches, parents, and athletes a budget which includes supplies and salary.

5. Providing school administrators with a tool for an economical means of employing an athletic trainer through the cooperative approach.

SERVICE MODEL

ROLE OF THE ATHLETIC TRAINER:

An athletic trainer is defined by the NATA as an allied health professional who has fulfilled the requirements for certification as established by the NATA board of certification. The certified athletic trainer works under the direction of a licensed physician when practicing the art and science of athletic training, which includes the following domains: 1. Prevention of athletic injuries; 2. Recognition and evaluation of athletic injuries; 3. Management, treatment and disposition of athletic injuries; 4. Rehabilitation of injuries; 5. Organization and administration of an athletic training program; and 6. Education and counseling of athletes (Board of Certification 1995). The individual hired as an athletic trainer for the cooperative would have to be a certified member of the NATA and be certified to teach First Aid and Cardiopulmonary Resuscitation (CPR). The athletic trainer must be certified to insure the knowledge of the person being hired and to reduce the liability risks inherent with the duties of athletic training.

The domains mentioned above will be the main focus of the athletic trainer, but the athletic trainer will do many other things for the high schools as well. One very important duty will be keeping records on each athlete. Each athlete's injuries and the management of the injury will need to be recorded. The athletic trainer will check the athlete's injury history (Appendix B) and assist in pre-participation physical exams (Appendix C) to learn of any potential problems. The athletic trainer will also be in communication with a doctor, so any special problems can be handled easily. The athletic

trainer and athletic training students will record injuries, (Appendix D) daily treatments, (Appendix E) and rehabilitation (Appendix F) and keep them on file. Each athlete's file will also contain shared responsibility for sport safety forms, assumption of risk forms, consent for treatment forms, (Appendix G) and any documentation from a doctor pertaining to that athlete. This file will follow an athlete during his or her athletic career. Tracking an athlete's medical history may be useful in preventing future injuries. In the event that the school has to defend itself in court, the athlete's file will be useful to show the protocols followed in the care of that athlete.

The athletic trainer will act as a liaison between the physician, the coach, and the parents. The athletic trainer can see a risk that a coach may not recognize and will be able to decide whether an athlete can continue to participate. This eliminates a scenario in which a coach continues to allow an athlete to play when the athlete is not capable of safely participating. Communication between the athletic trainer and the athlete's parents will educate the parents in the proper management of their son or daughter's injury. This will help the athlete, and his or her parents, deal with injuries in a positive manner. The athletic trainer will also help the athlete by educating him or her about injury care and prevention.

The athletic trainer will be able to teach First Aid and CPR to the coaches and teachers. In some schools the coaches and teachers are required to be trained in First Aid and CPR. Schools that do not require teachers and coaches have an up to date First Aid and CPR card may be neglecting their professional responsibility. First Aid

cards expire every three years and CPR cards expire every year. Having a person available to conduct the training, who is already being paid, would be a benefit for the schools.

The head athletic trainer can also teach a class for student athletic trainers. This will expand the class options given students and these student athletic trainers can assist the head athletic trainer and the coach when needed. Since the athletic trainer will be traveling between schools, there will be periods of time when the certified athletic trainer will not be on sight. The certified athletic trainer can set up an a emergency plan to be followed by the coach and the student athletic trainers when the certified athletic trainer is not available. By teaching interested students in the protocols of athletic training the coach will have help when injuries occur. The students could also monitor rehabilitation and treatments during the times the athletic trainer is absent. The coach and the students will have to remember that the students are not certified athletic trainers, but that they can be of assistance when injuries occur.

The person hired to be the athletic trainer for a cooperative will have to be very organized and be able to communicate well. The athletic trainer will have to deal with many coaches, athletes, parents and schools. An example of a position announcement is given in Figure 2. This announcement could be modified to fit the specific situation.

FIGURE 2

ATHLETIC TRAINER
POSITION ANNOUNCEMENT

POSITION: Head Athletic Trainer for a high school athletic training cooperative. A ten month position serving three rural high schools. This position requires organizing and delivering a comprehensive health care program that serves the student-athletes of each school. Duties include traveling between schools to monitor practices and games, teaching first aid and cardiopulmonary resuscitation to local teachers, coaches and students interested athletic training.

RESPONSIBILITIES:

1. Coordinate and administer a comprehensive health care program for all student-athletes.
2. Monitor practices and games.
3. Under the supervision of a physician, monitor rehabilitation and return to participation.
4. Serve as a medical liaison for coaches, athletes and parents.
5. Teach CPR and Advanced First Aid to teachers and coaches.
6. Instruct and supervise student athletic trainers.
7. The athletic trainer must live with in the boundaries of the cooperative.

QUALIFICATIONS:

1. Applicant must be a certified member of the National Athletic Trainers Association (NATA).
2. Applicant must be certified to teach Cardiopulmonary Resuscitation (CPR) and Advanced First Aid and Emergency Care.
3. Applicant must be well organized and have good communication skills.
4. Applicant with experience at the high school level is preferred.

SALARY: $18,000 a year, plus $3,000 a year for travel, and a good benefits package.

ORGANIZATIONAL STRUCTURE

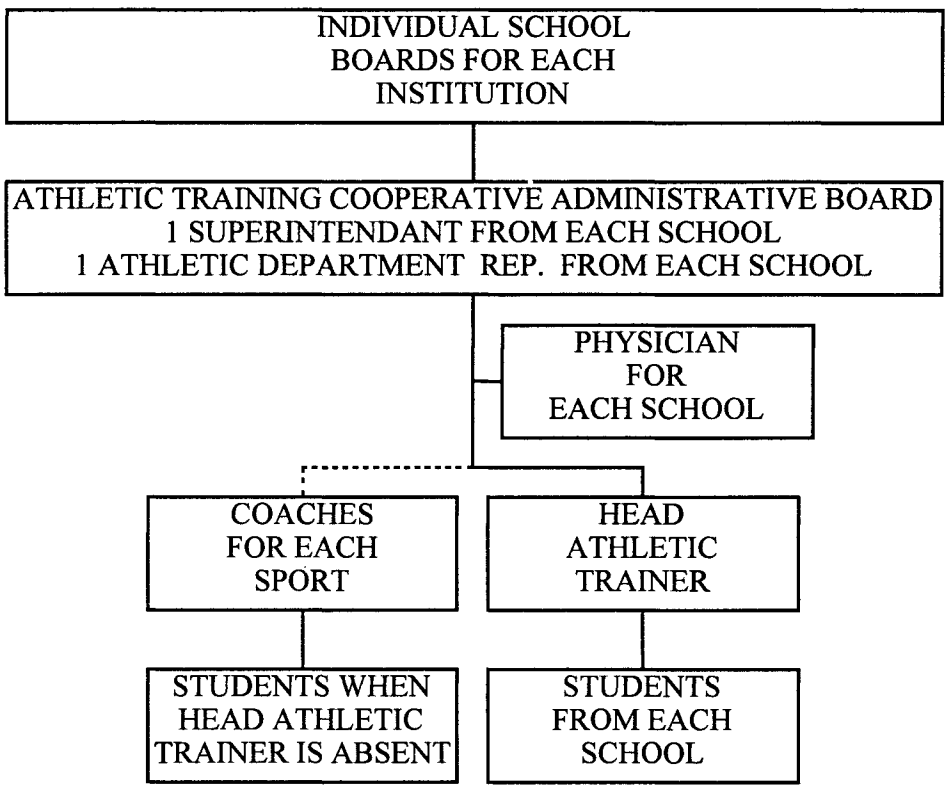
Protocols will need to be established to deal with the supervision and management of the athletic trainer and their actions. The organizational structure will be different for schools incorporating athletic training into an already existing cooperative than for schools making an independent cooperative, but the principles will be the same.

If the schools were to utilize an already existing cooperative, any administrative problems between the school districts and the athletic trainer would be handled by the Management Council and the Cooperative Director. The structure for this was outlined previously in Figure 1, page 6.

Schools in an independent cooperative would create a Board of Directors to deal with administrative problems. This Board will be made up of the Superintendent of each school and a representative directly related to each school's athletic program. This representative may be a coach or an athletic director. Each school would have two representatives on the athletic trainer's administrative board (Figure 3).

The management of the athletic training room and the related duties will be the responsibility of the certified athletic trainer. A physician will act as an advisor for the athletic trainer. Ideally there will be a physician for each school, but at least one physician is needed. There will be health care problems which will need to be referred to a physician and the communication between the athletic trainer and the physician will be critical.

FIGURE 3
INDEPENDENT COOPERATIVE ORGANIZATIONAL CHART



While on site, the athletic trainer will be responsible for injury management. This means the athletic trainer will care for injured athletes and determine when and if the athlete can continue to participate. The athletic trainer will inform the coach as to the status of the athlete in a timely manner. The athletic trainer, under the direction of the physician, will have the final say when an athlete can continue to participate in activities.

The athletic trainer will not be able to attend all practices and events. When the athletic trainer is not available the coach will be responsible for injury care. The athletic trainer will have an emergency plan in place for the coach to follow. The student athletic trainers can also be of assistance. This type of situation shows why it is essential for all coaches to have current First Aid and CPR training.

SERVICE SCHEDULE

The schedule will be an important aspect of the cooperative athletic trainer's job. Two schedules that could be used by the cooperative are provided. The ideal scenario allows for good communication allowing the schedule to be modified as needed.

In the first schedule, the athletic trainer alternates schools each day (Hossler, 1985). In the morning the athletic trainer would be available to teach first aid and sports medicine classes, give treatments, talk to coaches, and do record keeping. In the afternoon the athletic trainer would tape and do treatments, set up rehabilitative programs for injured athletes, and monitor practices. This schedule would work the best for the schools and the athletic trainer. The schedule would rotate as shown in Figure 4.

FIGURE 4
ALTERNATING DAYS SCHEDULE

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
A.M.	**SCHOOL A** Teach Class Meet with Coaches Do paper work Give treatments	**SCHOOL B**	**SCHOOL C**	**SCHOOL A**	**SCHOOL B**	Games
P.M.	Give Treatments Monitor Rehabilitation & Practice				Games	Games

The second example is a morning-afternoon rotation (Hossler, 1985). The athletic trainer would be at one school in the morning and another in the afternoon. This would allow the athletic trainer to see more athletes in a day, but would make scheduling teaching and coaches meetings more difficult. It would also increase the amount of time spent traveling. This schedule may be beneficial for short periods of time when there are many injured athletes in different schools. The schedule would rotate as shown in Figure 5.

Game coverage will be very important for the athletic trainer. The fact that there are three schools with multiple sports will make the athletic trainer's job very difficult, but possible. The athletic trainer will be responsible for covering home events. The athletic trainer will not travel with teams to away contests unless the team is a member of the cooperative. For example if cooperative school A plays cooperative school B, then the athletic trainer will be at the game and take care of both schools. In the event that multiple games occur on the same night, high risk sports, like football, will take precedent. As the athletic training cooperative system becomes familiar to the cooperative schools, scheduling can be modified to fit the needs of schools involved. As stated earlier communication between the schools and the athletic trainer will be essential.

FIGURE 5
MORNING AFTERNOON SCHEDULE

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
A.M.	**SCHOOL A** Teach Class Meet with Coaches Do paper work Monitor Rehabilitation	**SCHOOL C**	**SCHOOL B**	**SCHOOL A**	**SCHOOL C**	Games
P.M.	**SCHOOL B** Meet with Coaches Do paper work Monitor Rehabilitation & Practice	**SCHOOL A**	**SCHOOL C**	**SCHOOL B**	Games	Games

BUDGET

Each school is expected to purchase its own daily use supplies. Most schools already have an allocation for supplies in their athletic budget. The athletic trainer will use that money to order supplies used only for that school. Each school will also need to purchase a splint kit, which is very important to have for the proper management of athletic injuries. This kit can be used for every sport and will be used for many years. A list of suggested items and prices from Bio Medics are given as an example (Appendix H1). Some supplies may be purchased as a cooperative. These items will be shared by all cooperative members and will travel with the athletic trainer. The modalities will be used under the direction of a physician. If the equipment is well maintained it also will be used for many years (Appendix H2).

A cellular phone is not a mandatory item to run an athletic training room, but is a necessity in this situation. If the athletic trainer is always available by phone, communication will be much better between coaches, students, athletes, and the athletic trainer.

The salary, travel, and health benefits provided for the athletic trainer will be divided between the schools evenly. The total salary will be $18,000 with an added $3,000 for travel. Health benefits will be calculated at a rate of 22 percent of the athletic trainer's salary and will be $3,960. That means that each school will need to pay $6,000 a year in salary, $1,000 a year for travel, and $1,320 in health benefits. A complete overview of the athletic training cooperative's initial budget is found in figure 6.

FIGURE 6
INITIAL BUDGET

HEADINGS	SCHOOL A	SCHOOL B	SCHOOL C	TOTAL
SUPPLIES & EQUIPMENT	$1,750 ESTIMATED	$1,750 ESTIMATED	$1,750 ESTIMATED	$5,250
SUPPLIES & EQUIPMENT TO BE SHARED	$962 ESTIMATED	$962 ESTIMATED	$962 ESTIMATED	$2,886.35
SALARY	$6,000	$6,000	$6,000	$18,000
BENEFITS	$1,320	$1,320	$1,320	$3,960
TRAVEL	$1,000	$1,000	$1,000	$3,000
TOTAL	$11,032	$11,032	$11,032	$33,096

JUSTIFICATION

High school athletes, like college and professional athletes, get injured while participating in sports. College and professional athletes have access to an athletic trainer, and many high school athletes do not. This is of great concern because studies show that high school injuries are on the rise (Whieldon & Carny 1991, Garrick & Requa, 1978). Garrick and Requa show that high contact sports like football and wrestling had 81 injuries per 100 participants in 1978. Whereas, Whieldon and Carny show 96. 2 injuries per 100 participants in 1991. Some of the difference may be in the way the recorders in the survey view an injury, but in both studies an increase can be shown. In a three-year study done by the NATA on injuries that sideline football players three weeks or more, a rise of 20 percent was shown between 1986 and 1989 (NATA, 1989).

A study done by Goldhaber (1993) on parents awareness of severe brain injury from playing football gave some interesting facts. The parents surveyed for this study had a child that played high school football within the last five years. The survey found that the parents of high school football players were uninformed about both the risk of severe brain injury or the warning labels on football helmets. Most parents spoke of broken bones, knee injuries, sprains and strains, and shoulder injuries as hazards of football. Very few parents had received information from any source about the risks of head injury or had heard that no football helmet can provide complete protection against this hazard (Goldhaber 1993). This study was done particularly to discover the awareness of severe

injuries. The results show that most parents know that their child is at risk for injury while participating in football, but the parents don't understand that severe injuries can occur.

A survey of Michigan school superintendents concluded that many of the superintendents had a good idea of the increasing injury rates, and knew the duties and benefits of an athletic trainer. Many of the superintendents did not employ an athletic trainer, but did express a need for quality health care for injured athletes. When questioned, most superintendents felt that a certified athletic trainer would reduce the risk of litigation due to athletic injuries (Ray, 1987).

The two previous paragraphs bring up an interesting conflict. Superintendents and parents know that injuries are likely when participating in athletics. Superintendents and parents also know that funds are limited, and hiring a full time or part time athletic trainer is expensive. The athletic training cooperative, proposed in this paper, gives the superintendents and school districts another option for getting student athletes quality athletic health care.

The lack of athletic trainers in high schools means the coach is receiving most of the injury care duties. The coaches are the people most closely associated with the athletes on a daily basis. The coach must monitor the locker room, the field or court, schedule practice, watch film, make a game plan, and care for injuries. When asked if any certifications are required for high school coaches the Montana High School Association responded, "Only if the local school districts require them" (personal communication, telephone, February 1995).

In Montana a person can coach who has never taken CPR, First Aid, or a class on how to manage sport injuries.

In an article written by Hage and Moore (1981) it was stated "Coaches have to deal with pressure from school administrators, parents, and the medical professionals to reduce the rate of injury and improve medical care for high school sports." The article also stated, "Court decisions have increased the vulnerability of school districts to liability lawsuits from sports injuries," and "Smaller school district budgets that have forced athletic programs to operate under less than ideal conditions, even though most authorities agree that athletes in practice and games should be supervised by a physician, ministered to by a certified athletic trainer, coached by a certified coach, and served by a paramedic ambulance squad" (Hage & Moore, 1981, Rowe & Robertson, 1986).

Hage and Moore (1981) go on to discuss how different states make coaches do different things. One coach interviewed for the article, Ed Scantling from Lakeport, California, states, "You really put your career on the line each time you walk out on the field. It's a good feeling to have some training behind you so you know if you're doing the right thing. Some day you may be in a situation where you have to save a kid's life." David Adams, of the Tennessee Athletic Trainers Association, states, "We want somebody there besides the coach, because if somebody is hurt, the coach either neglects his coaching duty or neglects the injured person." Neglecting the athlete can be very dangerous for the athlete and the coach. Neglect can lead to liability, another important factor when discussing athletic injuries.

"No one associated with sports today is immune from litigation," says Herb Appenzeller, professor of sport management and author of *Sports and Law: Contemporary Issues.* Insurance companies have had to pay out large sums of money, so many sports organizations have found that the liability insurance they need to operate their program is unaffordable, or unavailable (Lubell A, 1987).

Coaches have been found liable for their failure to have and use adequate first aid training. Also, a coach in charge who performs unnecessary or detrimental acts will in all probability be found liable (Drowatzky JD, 1985). All this goes back to the knowledge of athletic injuries by the coach and the trust a school, and parents have in that coach. If an athlete is not properly cared for, someone is going to pay. Payment may come from the coach, the administration or the school district.

There are many cases involving inappropriate care administered by non-medical personnel in high school athletics. One example is the case of *Magabgab v. Orleans Parish School Board* (1980). During practice a football player fainted, apparently from the extreme heat and humidity. Due to delay and negligent care, the athlete died the following morning. The parents were awarded $42,000 for the loss of their child (Nygaard & Boone 1989).

A risk management program positions an athletic department for an effective defense to litigation. Hiring individuals who educate employees on how to handle emergency situations and receiving informed consent by educating the athlete and the athlete's parents are major parts of the risk management program. These needs can

be addressed by hiring a certified athletic trainer (Lubell A, 1987). A certified athletic trainer understands the importance of record keeping and keeping the parents involved in the athlete's injury care. Having a certified athletic trainer on staff will allow the coach to concentrate on coaching.

An athletic trainer also brings added support to school programs. One example of this support is a team doctor. The athletic trainer will be working with doctors. Ideally, one doctor can work with each school. This will help with game coverage and make it easier for injured athletes to see the doctor quickly. As the relationship builds between the doctor, the school, and the athletic trainer overall cost may decline. Supplies, equipment, and time may be offered more frequently by a doctor who feels a part of a school program.

The total cost of the proposed cooperative may look high at first, but one must remember the amount of service and equipment that is being proposed. Having an athletic trainer on staff is going to cause an increase in injury prevention, which will cause a decrease in health care costs. Most schools already have a line in the budget for supplies and equipment. Having an athletic trainer ordering supplies will save money because only supplies and equipment that are useful and needed by the athletes will be ordered. Sharing equipment with other members of the cooperative will allow each school to gain access to equipment that would otherwise be unavailable. This allows athletes quality injury care which can help prevent a minor injury from becoming a life long injury. Better care

also produces healthy athletes quickly, a primary goal of the athlete, the coach, and the parents.

The entire school will also benefit from having an athletic trainer on staff. The teachers will have someone who can teach them First Aid and CPR, the students can receive information about nutrition and healthy living practices, and the town will have another staff person, at the school, that cares about the well being of youth.

The budget also has added start up costs. The splint kit, electrical stimulation machine, hot pack machine, ultrasound machine, and backboard will not be purchased every year, which will cut $1,385.45 out of each school's budget for the second year. There will be some minimal yearly maintenance fees. Supplies not used can be stored for use the following years and with time, the supplies budget will be modified.

The salary paid by each school is reasonable compared to the work the athletic trainer will be doing for each school. A study done in 1992 found that high school athletic trainers average salary were $31,730 and the health benefits were $2,518. Both of these figures had a plus or minus $4,000 standard deviation (Rankin, 1992). Hiring an athletic trainer may cause school health insurance premiums to decrease, coaches will be freed from caring for injuries and dealing with medical personnel, administrators will be better prepared if litigation occurs, teachers have easy access to first aid and CPR re-certification, parent's medical costs will go down due to the quality health care available at the school, and the athlete and school district

will know that if an injury occurs, quality care is available immediately.

Montana's rural areas are ideal for an athletic training cooperative. By using the special education cooperative as a model, groups of small schools, with limited budgets, and inadequate athletic health care can benefit from the expertise of a certified athletic trainer. The student athletes will benefit, the towns will benefit, and the athletic trainers will benefit.

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APPENDIX A
MONTANA STATE LAW
20-7-451

20-7-451. Authorization to create full service education cooperatives. (1) A school district may contract with one or more other school districts to establish a cooperative to perform any or all education administrative services, activities, and undertakings that the school district entering into the contract is authorized by law to perform. The cooperative contract must be authorized by the boards of trustees of the districts entering into the contract.

(2) A cooperative contract may allow money allocated to a cooperative to be expended for:

(a) recruitment of professionals or employees for the cooperative; and

(b) facility rental and supportive services, including but not limited to janitorial and communication services.

History: En. Sec. 1, Ch. 471, L. 1979; amd. Sec. 1, Ch. 156, L. 1985; amd. Sec. 2, Ch. 343, L. 1989; amd. Sec. 1, Ch. 136, L. 1991.

Cross-References

Interlocal Cooperation Act, Title 7, ch. 11, part 1.

Trustees to execute all contracts in name of school district, 20-9-213.

Educational cooperative agreements, Title 20, ch. 9, part 7.

20-7-452. Detailed contents of full service education cooperative contracts. The contract authorized in 20-7-451 may include all necessary and proper matters but must specify the following:

(1) its duration, which may not be less than 3 years for purposes of providing special education services;

(2) the precise organization, composition, and nature of the cooperative;

(3) the purpose of the cooperative;

(4) the manner of financing the cooperative and establishing and maintaining a budget for the cooperative;

(5) the permissible method to be employed in accomplishing the partial or complete termination of the cooperative agreement and for disposing of property upon partial or complete termination;

(6) provision for a management board that is responsible for administering the cooperative and that is comprised of trustees of the contracting districts or their authorized representatives;

(7) the manner of acquiring, holding, and disposing of real and personal property used by the cooperative;

(8) any other necessary and proper matters.

History: En. Sec. 2, Ch. 471, L. 1979; amd. Sec. 3, Ch. 343, L. 1989; amd. Sec. 2, Ch. 136, L. 1991.

Cross-References

School property, Title 20, ch. 6, part 6.

Contracts, Title 28, ch. 2.

20-7-453. Submission of agreement to attorney general. (1) Every contract made under the provisions of 20-7-451 through 20-7-456 must, as a condition precedent to its performance, be submitted to the attorney general who must determine whether the contract is in proper form and compatible with the laws of Montana.

(2) The attorney general must approve any contract submitted to him pursuant to 20-7-451 unless he finds that it does not meet the conditions set forth in 20-7-451 and 20-7-452, in which case he must detail, in writing addressed to the school districts concerned, the specific respects in which the proposed contract fails to meet the requirements of law. Failure to disapprove a contract within 30 days of its submission constitutes approval of the contract by the attorney general.

History: En. Sec. 3, Ch. 471, L. 1979.

20-7-454. Final approval and filing of full service education cooperative contract. Within 10 days after approval by the attorney general and prior to commencement of its performance, a full service education cooperative contract made pursuant to 20-7-451 through 20-7-456 must be:

(1) submitted to the superintendent of public instruction who has final approval authority pursuant to the policies of the board of public education;

(2) filed with the county clerk and recorder of the county or counties in which the school districts involved are located; and

(3) filed with the secretary of state.

History: En. Sec. 4, Ch. 471, L. 1979; amd. Sec. 3, Ch. 136, L. 1991.

Cross-References Fees of County Clerk, 7-4-2631.

APPENDIX B
MEDICAL HISTORY FORM

ATHLETE'S MEDICAL HISTORY (January 13. 1995)

Name Last _____ First _____ Middle _____
SS# _____-_____-_____ Date of Birth ____/____/____ Age _____ Sex _____ Sport _____
Place of Birth _____ Religion _____ Marital Status _____
Local Address _____ Phone # (_____)_____
City _____ State _____ Zip _____
Mother/Guardian _____ Home Phone # (_____)_____
Address _____ Work Phone # (_____)_____
City _____ State _____ Zip _____
Father/Guardian _____ Home Phone # (_____)_____
Address _____ Work Phone # (_____)_____
City _____ State _____ Zip _____
Contact in Case of Emergency (Relative or non-relative not living with above):
Name _____ Home Phone # ( ) _____ Work Phone # ( ) _____

Has Any Blood Relative Ever Had: (Please check one)

	YES	NO	Whom
Sudden Death (Before Age 55)			
Blood Diseases (Sickle Cell, Leukemia)			
Diabetes			
Epilepsy			
Gout			
Heart Disease			
Hemophilia			
High Blood Pressure			
Mental Disorders			
Stroke			
Tuberculosis			
Drug and/or Alcohol Dependency			

Immunization Record Completed	YES	NO

GENERAL MEDICAL HEALTH HISTORY

Have you EVER had the following medical conditions?

	Y	N		Y	N		Y	N
High Blood Pressure			Asthma			Blood in Urine		
Rheumatic Fever			Exercise Induced Asthma			Frequent Urinary infection		
Rheumatic Heart Disease			Recurrent Sinusitis			Hearing Defect/Loss		
Pericarditis			Sinus Infection			Ear Infection		
Any Heart Disease?			Nasal Polyps			Muscular Disease		
Tumor, Growth, Cyst, Cancer			Nose Fracture			Birth Defects		
Any Ruptured Organs			Amnesia			Appendicitis		
Hepatitis			Meningitis			Stomach Ulcer (Peptic)		
Jaundice			Migraine Headaches			Gastrointestinal Bleed		
Gout			Seizure Disorder			Constipation		
Pleurisy			Goiter, Thyroid Disease			Hemorrhoids		
Pneumonia			Skin Disease			Hernia		
Polio			Diabetes			Arthritis		
Bronchitis			Sickle Cell Anemia/Trait			Joint Inflammations		
Frequent Respiratory infections			Anemia			Herpes (Oral)		
Tuberculosis			Abnormal Bruising			Herpes (Genital)		
Malaria			Abnormal Bleeding Tendency			Sexually Transmitted Disease		
Mumps			Blood Disease			HIV/ARC		
Mononucleosis			Blood Clots			Car/Air Sickness		
Red Measles			Kidney Disease			Nervous Breakdown		
Rubella			Kidney Stones			Mental Disorder		
Chicken Pox			Kidney Injury			Drug Dependency		
Eating Disorder			Anorexia Nervosa			Bulimia		
			Skin Conditions			Birthmark		

GENERAL MEDICAL HEALTH HISTORY (Continued)

Do you CURRENTLY have any of the following SYMPTOMS or PROBLEMS?

	YES	NO		YES	NO		YES	NO
Frequent Headaches			Recurring Coughing			Frequent Diarrhea		
Visual Changes			Chest Pain			Rectal Bleeding		
Ringing in Ears			Abdominal Pain			Unusual Fatigue		
Sore Throats			Muscle Cramps			Trouble Sleeping		
Sinus Congestion			Frequent Nausea					
Breathing Difficulty			Frequent Vomiting					

INTERNAL

Were you born with a complete and functional set of paired organs (eyes, ears, kidneys, ovaries/testicles, lungs)? Yes No

If not, which organs were involved? _____

Have you ever had surgery to repair or remove any organ (hernia, tonsils, appendix, spleen, etc.)? Yes No

1) If yes, which organ? _____ Repaired _____ Removed _____ Date: _____
   Physician _____ Address of Physician _____
2) If yes, which organ? _____ Repaired _____ Removed _____ Date: _____
   Physician _____ Address of Physician _____

CARDIAC	YES	NO
Have you ever felt dizzy, light-headed or passed out during or after exercise?		
Have you ever had chest pain while exercising?		
Have you ever had irregular heart beats or heart palpitations?		
Have you ever been told you have a heart murmur?		
Have you ever been seen by a heart specialist (cardiologist)?		
If yes? Who: Date:		
Have you ever had an echo-cardiogram?		
Have you ever had a heart stress test?		

VISION	YES	NO	
Have you ever been to an eye doctor			Date of last visit:
			Physician's name:
Do you wear glasses now?			
If yes, Reading only			Rx: R _____ L _____
Distance only			
All the time			
Do you wear contact lenses?			
If yes, Soft lenses			Rx: R _____ L _____
Hard lenses			
Do you have a second pair?			
Do you wear contact lenses/glasses to participate?			
Have you ever had an eye injury?			Date of incident:
Is your color vision normal?			Explain:
Have you ever worn a false eye?			

DENTAL - Do you now have or have you experienced any of the following?

	YES	NO	COMMENTS:
Do you have a bridge or false teeth?			
Fractured a tooth?			
Had a tooth knocked out?			
Do you wear a mouth protector?			
Do you wear orthodontic appliances?			

HEAT - Have you ever experienced any of the following?	YES	NO	COMMENTS:
Trouble with dehydration (Excessive loss of salt and water)			
Heat Stroke			
Heat Cramps (Due to fluid loss because of excessive heat)			
Heat Intolerance			

GENERAL MEDICAL HEALTH HISTORY (Continued)

ALLERGIES - Are you allergic to...?	YES	NO		YES	NO
Aspirin			Insect Bites/Stings		
Codeine			Tetanus Antitoxin or Serums		
Cortisone			Nail Polish or Cosmetics		
Sulfa			Any Foods:		
Anti-Inflammatories			Any Other Drug:		
Penicillin			Other:		
Hay Fever					

DRUG, FOOD SUPPLEMENTS AND MISCELLANEOUS AGENTS

Check the appropriate space according to YOUR use of the following items:

	Never	Rarely	Occasionally	Frequently
Vitamins				
Diet Pills				
Sleeping Pills				
Laxatives				
Alcoholic Beverages				
Antihistamines				
Anti-Inflammatories				
Caffeine				
Tobacco				
Other				

MISCELLANEOUS - Have you ever...?

	YES	NO		YES	NO
Worn hearing aids			Do you have any pins, staples, or wires in any part of your body		
Stuttered or stammered			Had any illness other than those already noted		
Coughed up blood			Missed a game because of illness		
Bled excessively after injury					
Been advised to have any operations					

FOR FEMALE ATHLETES ONLY. MALES PROCEED TO NEXT PAGE

WOMEN'S HEALTH HISTORY

	YES	NO	
Are your periods regular?			Comments:
Age of onset: _____			
Date of last period: _____			
Interval between periods: _____			
Duration of period: _____			
Is flow heavy?			
Heavy bleeding ever a problem?			
Do you ever have bleeding between periods?			
Do you experience any unusual discharge?			
Are cramps a frequent problem during your period			
Any past pregnancies/births?			
Are you on birth control medication?			If yes, what brand name?
Do you use a birth control device?			If yes, explain:
Do you do breast self examination?			
Do you have frequent urinary tract infections?			
Have you ever had a blood clot in your veins?			
Have you ever been treated for anemia?			
Have you ever been treated for an eating disorder?			
Have you ever had a gynecological exam?			If yes, date of last exam:
Have you ever had a pap smear?			If yes, date of last:
Have you ever had an abnormal pap smear?			

ORTHOPAEDIC HISTORY QUESTIONNAIRE

PLEASE PLACE A CHECK IN EITHER THE YES OR NO BOX.
IF YOU HAVE ANY QUESTIONS OR UNCERTAINTIES, PLEASE ASK ANY MEDICAL PERSONNEL FOR ASSISTANCE

HAVE YOU EVER INJURED OR CONSULTED A DOCTOR ABOUT ANY INJURY TO THE ...?

HEAD	YES	NO	DATE	COMMENTS:
1. Unconscious				
2. Dazed/Dizzy				
3. Knocked Out				
4. Concussion				
5. Headaches				
6. Injections				
7. Pains				
8. Fractures				
9. X-rays, CT, MRI				
10. Hospitalized				
11. Surgery				
12. Missed Practices				
13. Missed Games				
14. Other				

NECK	YES	NO	DATE	COMMENTS:
15. Sprain/Strain				
16. Stretches				
17. Pinches				
18. Disk Injury				
19. Dislocations				
20. Burners/Stingers				
21. Injections				
22. Pains				
23. Fractures				
24. X-rays, CT, MRI				
25. Hospitalized				
26. Surgery				
27. Missed Practices				
28. Missed Games				
29. Other				
30. Football Only - Do you wear a neck roll?			YES NO	

CHEST WALL	YES	NO	DATE	COMMENTS:
31. Fractured Collar Bone				
32. Fractured Ribs				
33. Sterno-Clavicular Separation				
34. Bruise				
35. Pains				
36. X-rays, CT, MRI				
37. Hospitalized				
38. Surgery				
39. Missed Practices				
40. Missed Games				
41. Other				

LOWER BACK	YES	NO	DATE	COMMENTS:
42. Sprain/Strain				
43. Nerve Pinches				
44. Disk Injury				
45. Referred Pain				
46. Pain Down Leg				
47. Numbness in Leg				
48. Weakness in Leg				
49. Bruise				
50. Injections				
51. Pains				
52. Fractures				
53. X-rays, CT, MRI				
54. Hospitalized				
55. Surgery				
56. Missed Practices				
57. Missed Games				
58. Other				

ORTHOPAEDIC HISTORY QUESTIONNAIRE (Continued)

SHOULDERS	YES	NO	DATE	COMMENTS:
59. Sprain/Strain				
60. A-C Separations				
61. Dislocations				
62. Partial Dislocations				
63. Shoulder Slips Out of Place				
64. Tendinitis				
65. Bursitis				
66. Injections				
67. Pain w/Overhead Activities				
68. Arm Goes "Dead" w/Trauma				
69. Fractures				
70. X-rays, CT, MRI				
71. Hospitalized				
72. Surgery				
73. Missed Practices				
74. Missed Games				
75. Other				

UPPER ARM/FOREARM	YES	NO	DATE	COMMENTS:
76. Strain				
77. Calcium Deposit				
78. Casted				
79. Bruise				
80. Injections				
81. Numbness In Fingers				
82. Pains				
83. Fractures				
84. X-rays, CT, MRI				
85. Hospitalized				
86. Surgery				
87. Missed Practices				
88. Missed Games				
89. Other				

ELBOWS	YES	NO	DATE	COMMENTS:
90. Sprain/Strain				
91. Bursitis				
92. Dislocations				
93. Joint Locking				
94. Casted				
95. Tendinitis				
96. Bruise				
97. Swelling				
98. Injections				
99. Pains				
100. Fractures				
101. X-rays, CT, MRI				
102. Hospitalized				
103. Surgery				
104. Missed Practices				
105. Missed Games				
106. Other				

WRISTS	YES	NO	DATE	COMMENTS:
107. Sprain/Strain				
108. Tendinitis				
109. Dislocations				
110. Casted				
111. Bruise				
112. Injections				
113. Pains				
114. Fractures				
115. X-rays, CT, MRI				
116. Hospitalized				
117. Surgery				
118. Missed Practices				
119. Missed Games				
120. Other				

ORTHOPAEDIC HISTORY QUESTIONNAIRE (Continued)

HANDS/FINGERS	YES	NO	DATE	COMMENTS:
121. Sprain				
122. Dislocations				
123. Casted/Splints				
124. Bruise				
125. Injections				
126. Pains				
127. Fractures				
128. X-rays, CT, MRI				
129. Hospitalized				
130. Surgery				
131. Missed Practices				
132. Missed Games				
133. Other				

PELVIS/HIPS	YES	NO	DATE	COMMENTS:
134. Sprain/Strain				
135. Groin Pulls				
136. Torn Muscles				
137. Dislocations				
138. Bruise				
139. Injections				
140. Pains				
141. Fractures				
142. X-rays, CT, MRI				
143. Hospitalized				
144. Surgery				
145. Missed Practices				
146. Missed Games				
147. Other				

THIGHS	YES	NO	DATE	COMMENTS:
148. Sprain/Strain				
149. Quad Pulls				
150. Hamstring Pulls				
151. Torn Muscles				
152. Calcium Deposits				
153. Bruise				
154. Injections				
155. Pains				
156. Fractures				
157. X-rays, CT, MRI				
158. Hospitalized				
159. Surgery				
160. Missed Practices				
161. Missed Games				
162. Other				

LOWER LEGS	YES	NO	DATE	COMMENTS:
163. Sprain/Strain				
164. Shin Splints				
165. Torn Muscles				
166. Bruise				
167. Injections				
168. Pains				
169. Painful-Tight Calf w/Activity				
170. Achilles Tendon Pain				
171. Stress Fracture				
172. Fractures				
173. X-rays, CT, MRI				
174. Hospitalized				
175. Surgery				
176. Missed Practices				
177. Missed Games				
178. Other				

ORTHOPAEDIC HISTORY QUESTIONNAIRE (Continued)

KNEES	YES	NO	DATE	COMMENTS:
179. Strained				
180. Sprained Ligament				
181. Torn Ligaments				
182. Torn Cartilage				
183. Knee Cap Injury				
184. Knee Cap Dislocation				
185. Osgood Schlatter's				
186. Bursitis				
187. Swelling				
188. Locking				
189. Giving Away				
190. Sudden Weakness, Shifting				
191. Wear Braces				
192. Casted				
193. Arthritis				
194. Chondromalacia				
195. Grinding				
196. Tendinitis				
197. Jumper's Knee				
198. Bruise				
199. Injections				
200. Pains				
201. Pain w/Stairs				
202. Pain w/Squats				
203. Fractures				
204. Arthrogram				
205. X-rays, CT, MRI				
206. Hospitalized				
207. Surgery				
208. Missed Practices				
209. Missed Games				
210. Other				

ANKLES	YES	NO	DATE	COMMENTS:
211. Sprain/Strain				
212. Tendinitis				
213. Dislocations				
214. Casted/Splinted				
215. Bruise				
216. Instability				
217. Giving Out				
218. Weakness				
219. Injections				
220. Pains				
221. Fractures				
223. X-rays, CT, MRI				
224. Hospitalized				
225. Surgery				
226. Missed Practices				
227. Missed Games				
228. Other				

FEET/TOES	YES	NO	DATE	COMMENTS:
229. Sprains				
230. Tendinitis				
231. Dislocations				
232. Turf Toe				
233. Casted/Splinted				
234. Orthotics				
235. Bruise				
236. Injections				
237. Pains				
238. Fractures				
239. X-rays, CT, MRI				
240. Hospitalized				
241. Surgery				
242. Missed Practices				
243. Missed Games				
244. Other				

ORTHOPAEDIC HISTORY QUESTIONNAIRE (Continued)

	YES	NO
Have you had or do you have any other medical problems or injuries not listed on this form?		
Do you have any medical or health problems that you are currently receiving medical treatment for?		
Is there any reason that you are not able to participate in athletics?		
Have you ever been advised by a doctor not to participate in athletics?		
Are there any additional health problems you would prefer to discuss privately with our team physician?		

If any of the first four questions above were answered with YES, please explain below:

List any special protective equipment you require or would like to have provided:

The undersigned, herewith,

A. Understands that any medical expense incurred due to the above pre-existing conditions and not directly attributable to athletic participation at The University of Montana is their personal responsibility.

B. Understands that the athletic medical insurance is secondary coverage and does not cover them until he or she has been cleared by an athletic physical examination.

C. Understands that he or she must refrain from practice while ill or injured, whether or not receiving medical treatment, and during medical treatment until he or she is discharged from treatment or is given permission by the clinical practitioner to restart participation despite continuing treatment.

D. Understands that having passed the physical examination does not necessarily mean that he or she is physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify him or her at the time of said examination.

E. Certifies that the answers above are correct and true.

Signature _____ Date _____

Upon completion of this History Form, it is to be reviewed and signed by a Staff Athletic Trainer.

Signature _____ A.T.,C Date _____

Upon the physical being administered. History Form reviewed and signed by Team Physician.

Signature _____ Date _____

From Rhinehart Athletic Treatment Center

APPENDIX C
PRE-PARTICIPATION PHYSICAL FORM

ATHLETE'S PHYSICAL (August 31, 1993)

Name Last _____ First _____ SS# _____ ___ _____ Sport ____
Date of Birth ____ ____ ____ Year in School 1 2 3 4 5 6 Marital Status: S M D
Local Address _____ Phone # (____ _____
City _____ State _____ Zip _____
Mother/Guardian/Wife _____ SS# _____ Home Phone # (____ _____
Address _____ Work Phone # (____ _____
City _____ State _____ Zip _____
Father/Guardian/Husband _____ SS# _____ Home Phone # (____ _____
Address _____ Work Phone # (____ _____
City _____ State _____ Zip _____
Contact in Case of Emergency (when none of above can be reached):
Name _____ Relationship _____ Home Phone # (____ _____
Address _____ Work Phone # (____ _____
City _____ State _____ Zip _____

INTERIM MEDICAL HISTORY: To be filled out by athletes returning to participation after less than 12 months absence.
Date of last exam _____

1. Have you been hospitalized or had any injury/illness since the most recent medical evaluation or reconsideration? YES NO
   If yes, what? _____
2. Are you currently ill in any way? YES NO
3. Have you had an injury (including concussion) since the most recent above medical evaluation or reconsideration. YES NO
4. Do you currently have any incompletely healed injury? YES NO
5. Are you taking any medication on a regular or continuing basis? YES NO
   If yes, what? _____
6. Are you taking any short-course medication for a specific current illness, etc.? YES NO
   If yes, what? _____
7. Do you know of, or do you believe there is, any health reason why you should not participate in the University of Montana intercollegiate athletic program at this time? YES NO
8. Do you wish to see the physician for any reason? YES NO

The undersigned, herewith,

A. Understands that he or she must refrain from practice or play while ill or injured, whether or not receiving medical treatment until he or she is discharged from treatment or is given permission by the clinical practitioner to restart participation despite continuing treatment.
B. Understands that having passed the physical examination does not necessarily mean that he or she is physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify him or her at the time of said examination.
C. Certifies that the answers above are correct and true.
   Signature _____ Date _____

HT ____ WT ____ # BP ____ SHOTS: TET/DIPH _____ BOOSTER _____ REQ'D IMM? Y N
BLOOD: HCT _____ RPR _____ URINE: SUGAR _____ ALB _____
GLASSES/CONTACTS WORN DURING ACTIVITY YES NO TYPE _____
UNCORRECTED VISION: R ____ L ____ CORRECTED VISION R ____ L ____
EENT

CHEST BREASTS HERNIA

STRUCTURAL EVALUATION

COMMENTS.

PASSED *PASSED WITH CONDITIONS* *PASSED WITH RESERVATIONS* *FAILED WITH CONDITIONS* *FAILED*

From Rhinehart Athletic Treatment Center

APPENDIX D
INJURY RECORD FORM

History:

Inspection:

Palpation:

Functional Testing:

Treatment: _____ AT _____

Clinical Impression: R L B _____

Date Reported: _____ Date Injured: _____ Sport: _____

Name: _____ SS#: _____

From Rhinehart Athletic Treatment Center

APPENDIX E
DAILY TREATMENT RECORD

DAILY TREATMENT RECORD _____ 48 ___

AME	SPT	BP TREATED	WWP	CWP	CON	CPA	HPA	IMA	US	EMS	TENS	SWD	PAR	REC	PRG	TOD

WWP=warm whirlpool CWP=cold whirlpool CON=contrast CPA=cold pack HPA=hot pack IMA=ice massage US=ultrasound EMS=electric muscle stim TENS=transcutaneous elec stim PAR=paraffin SWD=shortwave diathermy REC=recorder PRG=progress (N/new, =same as last treatment, +/improved, -/no improvement, R/regress) TOD=time of day

From Rhinehart Athletic Treatment Center

APPENDIX F
REHABILITATION TREATMENT RECORD

TREATMENT RECORD

NAME _____ AGE _____
ADDRESS _____ PHONE # _____
REFERRED BY _____ PHONE # _____ DATE _____
DIAGNOSIS _____

RECORD OF TREATMENT

MONTH/YEAR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

PLAN OF TREATMENT

From Rhinehart Athletic Treatment Center

APPENDIX G
SHARED RESPONSIBILITY
ASSUMPTION OF RISK
CONSENT FOR TREATMENT

SHARED RESPONSIBILITY FOR SPORT SAFETY

Participation in sport requires an acceptance of risk of injury. Student-athletes rightfully assume that those who are responsible for the conduct of sport have taken reasonable precautions to minimize the risk of significant injury. Periodic analysis of injury patterns continuously leads to refinements in the rules and/or other safety guidelines.

However, to legislate safety via the rule book and equipment standards alone, while often necessary, is seldom entirely effective. To rely on officials to enforce compliance with the rules book is as insufficient as to rely on warning labels to produce behavioral compliance with safety guidelines. Compliance implies respect on everyone's part (student-athlete, coach, athletics trainer, physician, athletics director) for the intent and purpose of rules and guidelines.

Student-athletes, for their part, should comply with and understand the rules and standards that govern their sports. Coaches should appropriately acquaint the student-athlete with risks of injury and with the rules and practices they are employing to minimize the student-athlete's risk of significant injury while pursuing the many benefits of the sport. The athletics trainer and team physician should be responsible for injury-prevention efforts (where possible) and the care of those injuries that occur. The athletics program, via the athletics administrator, should be responsible for providing a safe environment. The student-athlete and the athletics program have a mutual need for an informed awareness for the risks being accepted and for sharing the responsibility for minimizing those risks.

_____ _____

Signature Date

ASSUMPTION OF RISK

I understand that while I am participating in intercollegiate athletics, there is a risk of injury. I understand that such an injury can range from a minor injury to a major injury. Such injuries could cause permanent disability such as paralysis, permanent bone or joint injury, other chronic disabling conditions and even death.

I hereby accept and assume the risk of injury and understand the possible consequences of such injury.

_____ _____

Signature Date

CONSENT FOR TREATMENT

I understand that I may be injured while participating in athletics at the University of Montana. I authorize the school to obtain through a physician of its choice any emergency care that may become necessary while participating in or traveling under the University of Montana's intercollegiate athletic program. I also authorize the University athletic team physician and athletic trainers to administer those treatments necessary.

_____ _____

Signature Date

From Rhinehart Athletic Treatment Center

APPENDIX H1
EACH SCHOOL'S
SUPPLIES AND PRICES

SUPPLIES:

p.18	3" Elastikon	49.90/doz. x 3 = 149.70	
p.18	Underwrap	28.90/case x 3 = 86.70	
p.15	Foam Horseshoes	12.90/sheet	
p. 8	Skin Lube	5.65/2lb	
p. 2	Tongue Depress.	4.00/box100 x 2 = 8.00	
p.9	Tape Adherent	79.45/case	
p. 7	Flexall	56.30/7lb	
p.14	6" Elastic Bandages	16.80/doz. x 2 = 33.60	
p.14	4" Elastic Bandages	13.80/doz. x 2 = 27.60	
p.14	Double 4" Elastic Bandages	18.60/doz. x 2 = 37.20	
p.18	1.5" Tape	40.40/case x 10 =404.00	
p.15	2" Moleskin	15.00/roll	
	Water Bottle 32oz	1.30/ea. x 12 = 15.60	
p.102	Betadine	22.20/gal	
p.102	Caladryl Cream	4.00/ 1.5oz x 2 = 8.00	
p. 2	1/4" Steri-Strips	75.10/box	
p.2	Cotton Tip Appl.	3.50/box x 2 = 7.00	
p.4	Gauze Pads 3x3	4.65/box x 2 = 9.30	
p.1	1" Bandaids	2.15/box x 3 = 4.30	
p.47	Heavy Ice Bags	55.00/roll	
p.xv	Latex Gloves	7.50/box x 4 = 30.00	
p.102	Domeborro	22.30	
p.104	Antibiotic Ointment	15.60/doz.	
p.103	Hydrogen Peroxide	.50/16oz x 3 = 1.50	
p.	Coolers 10 gal.	48.20	
p.32	Zorbicide	15.85/bottle x 2 = 31.70	
p.69	Tape Scissors	8.00/ea.	
p.70	Twizers	1.05/ea.	
p.69	Trainers Angle	39.55/ea.	
		718.05	1,310.50

Prices from Micro Bio-Medics, Inc. 1995

APPENDIX H2
SHARED EQUIPMENT
AND SUPPLIES

SPLINT KIT:	p.95	256.25	
Leg-Arm-Cervical Airless Splint-Air Pump-Velcro Extenders			
p.96	SAM Splint	13.15/ea.	
p.36	Triangular Bandages	6.70/ea.	
p.94	Philli Collors (L,M,S)	21.80/ea x 3 = 65.40	
p.32	Knee Splint	56.35/ea.	
p.36	Sling	2.80/ea.	
p.78	Crutches	22.80/pr.	
			423.45
SHARED SUPPLIES:			
p.48	Hot Pack Machine		
	4-pack	408.65	
	1-neck	15.80	
	10x12 covers	13.25 x 3 =	39.75
p.54	High Voltage Stimulator	850.75	
	Cell Phone		
p.53	Ultrasound	1395.00	
p.98	Aluminum Backboard	176.40	
			2,886.35

Prices from Micro Bio-Medics, Inc. 1995