



EMERGENCY ACTION PLAN FOR ATHLETICS

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ST. PAUL'S SCHOOL EMERGENCY ACTION PLAN FOR ATHLETICS
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ST. PAUL'S SCHOOL

EMERGENCY ACTION PLAN FOR ATHLETICS OVERVIEW

Introduction

Emergency situations may arise at anytime during athletic events. Expedient action must be taken in order to provide the best possible care to the sport participant of emergency and/or life threatening conditions. The development and implementation of an emergency action plan will help ensure that the best care will be provided.

As emergencies may occur at anytime and during any activity, all school activities workers must be prepared. Athletic organizations have a duty to develop an emergency action plan that may be implemented immediately when necessary and to provide appropriate standards of emergency care to all sports participants. As athletic injuries may occur at any time and during any activity, the sports medicine team must be prepared. This preparation involves formulation of an emergency action plan, proper coverage of events, maintenance of appropriate emergency equipment and supplies, utilization of appropriate emergency medical personnel, and continuing education in the area of emergency medicine and planning. Hopefully, through careful pre-participation physical screenings, adequate medical coverage, safe practice and training techniques and other safety avenues, some potential emergencies may be averted. However, accidents and injuries are inherent with sports participation, and proper preparation on the part of the sports medicine team should enable each emergency situation to be managed appropriately.

Components of the Emergency Action Plan

These are the basic components of every emergency action plan for athletics:

1. Emergency Personnel
2. Emergency Communication
3. Emergency Equipment
4. Roles of Certified Coaches and Administrators
5. Venue Directions with Map

The St. Paul's School Emergency Action Plan also includes the following:

- Basic Injury Management for Coaches
- Basic Taping Techniques for Coaches

Emergency Plan Personnel

With athletic practice and competition, the first responder to an emergency situation is typically a coach. The type and degree of sports medicine coverage for an athletic event may vary widely, based on such factors as the sport or activity, the setting, and the type of training or competition. Certification in cardiopulmonary resuscitation (CPR), first aid, prevention of disease transmission, and emergency action plan review is required by St. Paul's School for all athletics personnel associated with practices, competitions, skills instruction, and strength and conditioning.

The development of an emergency action plan cannot be complete without the formation of an emergency team. The emergency team may consist of a number of healthcare providers including physicians, emergency medical technicians, coaches, parents, and, possibly, other bystanders. Roles of these individuals within the emergency team may vary depending on various factors such as the number of members of the team, the athletic venue itself. There are four basic roles within the emergency team. The first and most important role is establishing safety of the scene and immediate care of the athlete. Acute

care in an emergency situation should be provided by the most qualified individual on the scene. In most instances, this role will be assumed by the Certified Athletic Trainer, although if the team physician is present, he/she may be called in. The second role, EMS activation, may be necessary in situations where emergency transportation is not already present at the sporting event. This should be done as soon as the situation is deemed an emergency or a life-threatening event. Time is the most critical factor under emergency conditions. Activating the EMS system may be done by anyone on the team. However, the person chosen for this duty should be someone who is calm under pressure and who communicates well over the telephone. This person should also be familiar with the location and address of the sporting event. Typically, the school administrator is the best choice to fulfill this role. The third role, equipment retrieval may be done by anyone on the emergency team who is familiar with the types and location of the specific equipment needed. Student athletic trainers and coaches are good choices for this role. The fourth role of the emergency team is that of directing EMS to the scene. One member of the team should be responsible for meeting emergency medical personnel as they arrive at the site of the emergency. Depending on ease of access, this person should have keys to any locked gates or doors that may slow the arrival of medical personnel. A student athletic trainer, administrator, or coach may be appropriate for this role.

Roles within the Emergency Team	
1.	Establish scene safety and immediate care of the athlete
2.	Activation of the Emergency Medical System
3.	Emergency equipment retrieval
4.	Direction of EMS to scene

Activating the EMS System	
Making the Call:	
911 (all emergencies in Idaho and Utah)	
Providing Information:	
<ul style="list-style-type: none"> • name, address, telephone number of caller • nature of emergency, whether medical or non-medical * • number of athletes • condition of athlete(s) • first aid treatment initiated by ATC/Physician • specific directions as needed to locate the emergency scene (i.e. "Come to the faculty parking lot on Elm St.") • other information as requested by dispatcher 	

When forming the emergency team, it is important to adapt the team to each situation or sport. It may also be advantageous to have more than one individual assigned to each role. This allows the emergency team to function even though certain members may not always be present.

Emergency Communication

Communication is the key to quick emergency response. Athletic trainers and emergency medical personnel must work together to provide the best emergency response capability and should have contact information established as a part of pre-planning for emergency situations. Communication prior to the event is a good way to establish boundaries and to build rapport between both groups of professionals. If emergency medical transportation is not available on site during a particular sporting event, then direct communication with the emergency medical system at the time of injury or illness is necessary.

Access to a working telephone or other telecommunications device, whether fixed or mobile, should be assured. The communications system should be checked prior to each practice or competition to ensure proper working order. A back-up communication plan should be in effect should there be failure of the primary communication system. The most common method of communication is a cellular telephone, which is preferred if available. At any athletic venue, whether home or away, it is important to know the location of a workable telephone. Pre-arranged access to the phone should be established if it is not easily accessible.

Emergency Equipment

All necessary emergency equipment should be at the site and quickly accessible. Personnel should be familiar with the function and operation of each type of emergency equipment. Equipment should be in good operating condition, and personnel must be trained in advance to use it properly. Emergency equipment should be checked on a regular basis and use rehearsed by emergency personnel. The emergency equipment available should be appropriate for the level of training for the emergency medical providers. Creating an equipment inspection log book for continued inspection is strongly recommended. The school's Athletic Director and Certified Coaches should be trained and educated on the care of the medical equipment.

It is important to know the proper way to care for and store the equipment as well. Equipment should be stored in a clean and environmentally controlled area. It should be readily available when emergency situations arise

Medical Emergency Transportation

Emphasis should be placed at having an ambulance on site at high risk sporting events. In the event that an ambulance is on site, there should be a designated location with rapid access to the site and a cleared route for entering/exiting the venue. If an ambulance is not present at an event, entrance to the facility should be clearly marked and accessible. In the event of an emergency, the 911 system will still be utilized for activating emergency transport.

In the medical emergency evaluation, the primary survey assists the emergency care provider in identifying emergencies requiring critical intervention and in determining transport decisions. In an emergency situation, the athlete should be transported by ambulance, where the necessary staff and equipment is available to deliver appropriate care. Emergency care providers should refrain from transporting unstable athletes in inappropriate vehicles. Care must be taken to ensure that the activity areas are supervised should the emergency care provider leave the site in transporting the athlete. Any emergency situations where there is impairment in level of consciousness (LOC), airway, breathing, or circulation (ABC) or there is neurovascular compromise should be considered a "load and go" situation and emphasis placed on rapid evaluation, treatment and transportation. In order to provide the best possible care for St. Paul's School athletes, *all emergency trauma transports are to be sent to the hospital chosen by parents and/or emergency personnel.*




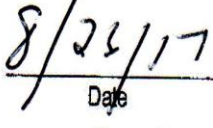
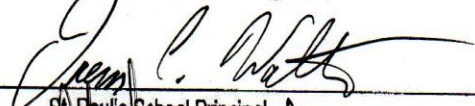

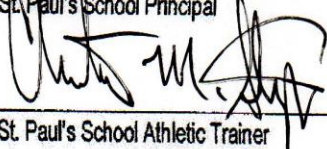
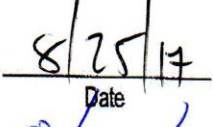
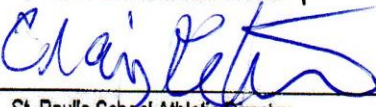

Non-Medical Emergencies

For the following non-medical emergencies: fire, bomb threats, severe weather and violent or criminal behavior, refer to the school's crisis management procedures (red, spiral bound book) and follow the instructions provided.

Conclusion

The importance of being properly prepared when athletic emergencies arise cannot be stressed enough. An athlete's survival may hinge on how well trained and prepared athletic healthcare providers are. It is prudent to invest athletic department "ownership" in the emergency action plan by involving the athletic administration and sport coaches as well as sports medicine personnel. The emergency action plan should be reviewed at least once a year with all athletic personnel, along with CPR and first aid refresher training. Through development and implementation of the emergency action plan, St. Paul's School helps ensure that the athlete will have the best care provided when an emergency situation does arise.

Approval and Acceptance of the St. Paul's School Emergency Action Plan for Athletics

Approved by		
	St. Paul's School Team Physician	Date
Approved by		
	St. Paul's School Team Physician	Date
Approved by		
	St. Paul's School Principal	Date
Approved by		
	St. Paul's School Athletic Trainer	Date
Approved by		
	St. Paul's School Athletic Director	Date



**Part II:
ATHLETIC POLICIES AND PROCEDURES**

Over the Counter Medications

Coaches are not allowed to dispense any type of medication and should strongly discourage athletes from carrying their own. Several over the counter medications are available in the athletic training room. These include Tylenol, ibuprofen, cough drops, antacids and anti-diarrhea medications.

Physician Referrals

Any athlete who sees a physician for an injury sustained while participating in a sport or activity at St. Paul's School must inform the athletic trainer immediately. Any athlete who does not notify the athletic trainer should not be allowed to resume practice or participate in games.

Getting Hurt on the Field

If an athlete is injured on the field, no matter what type, **he should never be moved** if a head or neck injury is suspected. If the injured athlete has a head or spinal injury and is moved, the vertebrae can shift and sever the spinal cord. A severed spinal cord can mean permanent paralysis for that athlete. Thus, you should **never move an injured athlete!** In the case of football, wrestling, and home basketball games, an athletic trainer will always be present. At other sporting events, however, it will be necessary for the coach to evaluate the injury and use a "common sense" approach to whether or not it will be necessary to call for an ambulance. **If in doubt, dial 9-1-1.**

Other Injury Management

In the event that an athlete sustains an injury, it is his responsibility to notify the coach immediately after that injury is sustained. The coach will then evaluate the injury and give treatment instructions to the athlete, which may include seeing the athletic trainer. In most cases, please note that the coaches still want the injured athletes to attend practice as an observer. If an athlete is ill, the athlete or his parents should contact the coach of that sport.

Sports Medicine Forms

Before an athlete can participate in any sport or activity, the athlete must have his parent(s) complete, sign and return the Pre-Participation Physical Form. This form is available from the athletic secretary or online at the school's website and must be returned to the athletic secretary before the athlete will be allowed to participate. The form also authorizes emergency consent to treat in the event a parent or guardian cannot be reached.

Coaching First Aid & CPR Training

In accordance with the Louisiana High School Athletic Association's recommendations, all coaches, both head and assistant, at St. Paul's School must be trained in first aid and CPR. These first aid and CPR classes will be conducted at the request of the school's administration. All attendees will certify in Adult CPR and AED.

Travel Kits for Coaches

The athletic trainer will supply a first aid kit to all sports. Coaches should maintain their own kit. Supplies are limited. Please notify the athletic trainer if your kit needs to be refilled.

Injury Privacy and the Law

The Health Insurance Portability and Accountability Act (HIPAA) prohibits any dissemination of medical information to non-authorized parties. Administrators, coaches, and sports medicine personnel should never release any information about an athlete's injury or condition to any person without expressed consent of the athlete's parent.



**Part III:
BASIC INJURY MANAGEMENT FOR SPORT COACHES**

Bone Injuries

Recognizing Fractures:

An open fracture will typically be self evident due to the exposed bone. The following clues suggest you are dealing with a probable closed fracture:

- The athlete felt a bone break or heard a "snap";
- The athlete feels a grating sensation when he/she moves a limb;
- One limb appears to be a different length, shape or size than the other, or is improperly angulated;
- Reddening of the skin around a fracture may appear shortly after the injury is sustained;
- The athlete may not be able to move a limb or part of a limb (e.g., the arm, but not the fingers), or to do so produces intense pain;
- Loss of a pulse at the end of the extremity;
- Loss of sensation at the end of the extremity;
- Numbness or tingling sensations;
- Involuntary muscle spasms;
- Other unusual pain, such as intense pain in the rib cage when a patient takes a deep breath or coughs.

Ice On A Fracture Usually Makes It Throb Worse...


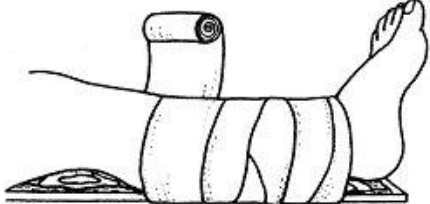
Splinting

Any suspected fracture should always be splinted before the athlete is allowed to move.

Splint the joint above and below the affected area.

How to Splint:

1. **Check pulse.** Then remove clothing from the injured part. Don't force a limb out of the clothing, though. You may need to cut clothing off with scissors to prevent causing the athlete any additional pain.
2. Apply a cold compress or an ice pack wrapped in cloth.
3. Place a splint (or boards) on the injured part by keeping the injured limb in the position you find it. Add soft padding around the injured part placing something firm (like a board or rolled-up newspapers) next to the injured part, making sure it's long enough to go past the joints above and below the injury keeping the splint in place with first-aid tape. **Re-check pulse.**
4. Seek medical care, and don't allow the athlete to eat or drink anything, in case medication or surgery is needed.

	
<p style="text-align: center;">Wrist, Arm & Shoulder Sling and Swath</p>	<p style="text-align: center;">Ankle and Lower Leg</p>

Concussions

“Any transient neurological dysfunction resulting from a biomechanical force that may or may not result in a loss of consciousness”

(Giza & Hovda, 2001, p. 228)

Recognizing Concussion

Concussions do not always involve a loss of consciousness. ANY traumatic blow to the head or to another part of the body (which causes a whiplash effect to the head) should be considered as a mechanism of concussion injury. While headache is the most common symptom of concussion, all people will experience concussion differently. Therefore, all of the potential signs and symptoms of concussion should be considered. A symptom checklist can assist the evaluator in making a more objective return to play decision.

If a player sustains any signs or symptoms of concussion, he must be pulled from play. Only a physician may clear the athlete to return to play. Please see the SPS Concussion Protocol.

Concussion Signs and Symptoms

Amnesia	Poor concentration	Sensitivity to light
Loss of orientation	Easily distracted	Headache
Balance problems	Personality changes	Sluggishness
Memory problems	“Glassy Eyed”	Inappropriate emotions
“Bell rung”	Excessive sleep	change in personality
Nausea	Ringing in the ears	Sensitivity to noise
Dazed or Confused	Fatigue	Irritability
Nervousness	Sadness	sleep disturbance
Depression	Feeling “in a fog”	Loss of consciousness
Numbness or tingling	Seeing “stars”	Vacant stare
Double vision	Feeling “slowed down”	Vomiting
Drowsiness		

ALL ATHLETES WHO GET “DINGED” AND EXHIBIT ANY OF THESE SIGNS OR SYMPTOMS SHOULD BE REFERRED IMMEDIATELY TO A PHYSICIAN!!!

Environmental

Lightning

**IF YOU SEE LIGHTNING ANYWHERE IN THE SKY, TAKE ALL ATHLETES INSIDE.
PLEASE SEE THE SPS LIGHTNING PROTOCOL.**

Avoiding Heat Related Illnesses

People suffer heat-related illness when the body's temperature control system is overloaded. The body normally cools itself by sweating. But under some conditions, sweating just isn't enough. In such cases, a person's body temperature rises rapidly. Very high body temperatures may damage the brain or other vital organs. Factors that contribute to heat-related illness include high humidity, obesity, fever, dehydration, poor circulation, sunburn, and drug and alcohol use. To try to prevent heat related illnesses

- Drink plenty of fluids before, during and after exertion;
- Include electrolytes in the fluids (salt, sodium, potassium);
- Wear light clothing on hot days;
- Wear sunscreen;
- Schedule practices during cool periods (avoid 10am to 2pm) and acclimate athletes to heat gradually.

Heat Related Injuries (*cramping, exhaustion, rapid and shallow breathing, weak pulse, moist pale skin, sweating*)

- Remove athlete from the hot environment. Place in a cool environment (air conditioned);
- Loosen athlete's clothing and fan. Watch for shivering;
- Have athlete lay down with legs elevated;
- Give athlete water (if not nauseated);
- If athlete is having muscle cramps, apply moist towels over cramping areas.

Cold Related Injuries

- Get the athlete out of the cold environment;
- Warm the affected area (gradually);
- If the injury is to an extremity, check pulses, splint, and recheck pulses;
- Do not rub or massage the area, and do not re-expose it to cold.

If the area is white and waxy, grayish colored, or blotched, suspect frostbite and send to hospital.

Bee Stings (*noticeable bite/sting, blotchy skin, pain or itching, burning, weakness, chills, fever, nausea, etc*)

The two greatest risks from most insect stings are allergic reaction (which occasionally, in some individuals could be fatal) and infection (more common and less serious). If an athlete is stung by a bee, wasp, hornet, or yellow jacket, follow these instructions closely:

- Check to see if the stinger is injected. Do not try to pull it out as this may release more venom; instead gently scrape it out with a blunt-edged object, such as a credit card or a dull blade;
- Wash the area carefully with soap and water. This should be continued several times a day until the skin is healed;
- Apply a cold or ice pack, wrapped in cloth for a few minutes;
- Apply a paste of baking soda and water and leave it on for 15 to 20 minutes;
- Instruct athlete to take acetaminophen (Tylenol) for pain.

If the athlete acknowledges an allergy to stings or has trouble breathing, call 9-1-1

Equipment Concerns

Recommended Procedure for Football Helmet Fitting Session

Coaches have a responsibility to do everything they can to ensure the safety of their players. That begins with making sure their equipment fits properly before they even set foot on the field. Every player is someone's child. Follow these suggestions and you are on your way to a safer season.

- Determine the **normal hair length of the athlete**. His hair length when he is fit may not be the same length as it will be during the season, especially if the fitting is done in the off-season, e.g., in spring before the players leave for the summer.
 - Try to **wet the athlete's hair prior to fitting the helmet**. A damp cloth or some water applied to the hair makes the initial fitting easier and will also approximate game and practice conditions when the players perspire.
 - Check to see if player's **ear openings** are in center of helmet ear openings or below center. If the helmet's ear openings are too high, the helmet is too small or possibly the inner liner may be over inflated. If the helmet ear openings are too low, the helmet is too big or the inner liner is under inflated.
 - Check to see that the **eyebrows** are approximately 1–1/2" below the helmet's front rim. A general rule of thumb is to use 1–1/2 finger widths. If there is a gap of more than 1 inch, generally the helmet is too small and if there is less, it is too large.
 - Try to **rotate the helmet** side-to-side. There are various ways to do this. One is to ask the player to "bull" his neck. Grab the faceguard in the middle and attempt to move the helmet from side to side. There should be some movement of the forehead skin and hair with the helmet, but it should not slip. Using the center loops on the faceguard as a guide, the nose should stay within a line directly down the center of the helmet and the center of the loop. If the nose moves to the right and left beyond these loops, generally the fit needs to be adjusted or the helmet is still too big.
 - Check the **crown adjustment** of the helmet. Again, there are various ways to do this. One method is to request the player to clasp his hands over the crown of the helmet and push straight down. The pressure should be felt on the crown. This test also cross-checks the eyebrow test.
 - Check the **forehead pressure** and back-to-front fit. One method to do this is to have the player rotate his hands down to the rear of the helmet from the crown test. Keep the hands clasped together and attempt to push the helmet forward. Usually a gap of a finger width or less between the forehead and front sizer is acceptable.
 - Check the **jaw pads** to see that they fit correctly. *They should be neither undersized nor oversized.* They should follow the contours of the cheeks.
 - Check the **chin strap** fit. *The function of the chin strap is to hold the helmet in place.* Make sure the cup is centered on the point of the chin and all four straps have the slack taken out. Begin fitting with the back or lower chin strap first. It is important that the high hook-up chin straps go underneath the facemask.
 - Check the **faceguard**. There should be adequate spacing between the faceguard and the tip of the nose.
 - Check the fit in the **rear of the helmet**. The occipital lobe should be covered by the shell. The rear of the helmet should cradle the neck. It should not chafe from a tight fit, nor leave a large gap from a loose fit.
 - Check the player's **vision**, both peripherally, as well as up and down. Peripherally, the player should be able to track a finger about 180 degrees, up and down to about 75 degrees.
- **CHECK ALL HELMETS REGULARLY (every other day) TO BE SURE THEY HAVE AIR**
 - **CHECK MOUTHGUARDS DAILY**
 - **NEVER ALLOW ATHLETES TO CUT MOUTHGUARDS**
 - **REPLACE WORN DOWN MOUTHGUARDS**

Hydrating Athletes

Fluid Replacement

Athletes should be especially cautious to stay well-hydrated. While water is essential, it is also imperative to replace lost electrolytes. Consuming sports drinks such as **PowerAde** and **Gatorade** is one way of doing this. High energy drinks such as *Red Bull* and *Monster*, however, are **not recommended** as a safe way to replenish electrolytes and hydrate the body.

Generally speaking, the most important thing is that the athlete stays well-hydrated while not getting too much sugar intake. Here are some general guidelines to follow:

- The athlete should drink plenty of water before athletic participation. Experts recommend 17-20 fl oz of water or a sports drink be consumed 2 to 3 hours before activity.
- Experts recommend 7-10 fl oz every ten to twenty minutes during activity. Those who sweat more should consume more;
- Cool beverages are best (50-59 degrees F).
- Sports drinks containing high amounts of carbohydrate are most beneficial for an athlete if consumed 2-3 hours prior to activity;
- Sports drinks containing fructose should be avoided entirely. Fructose can lead to gastric distress.
- Sports drinks, fruit juices, carbohydrate gels, sodas and other beverages containing more than 8% carbohydrate concentration are not recommended as the sole source of fluid during exercise.
- Recognize signs of dehydration: thirst, irritability, general discomfort, followed by headache, weakness, dizziness, cramps, chills, vomiting, nausea, heat sensations, and decreased performance.
- A moderate amount of sodium chloride in fluid-replacement beverages can be beneficial in offsetting electrolyte imbalances that result from loss of sweat.

Encourage athletes to drink 16-32 ounces of fluid for every pound lost during activity.



Skin Disorders

Impetigo & Staff Infection

If undetected, the MRSA virus can be fatal. It is absolutely imperative that all rashes and red areas be reported to an athletic trainer and evaluated by a physician. To prevent MRSA, athletes should practice good hygiene. Practice and game clothes should be washed daily. Lockers should be cleaned and aired out nightly. Athletes should shower with soap after engaging in any physical activity. Towels and water bottles should never be shared.

Signs of MRSA

- skin boils or blemishes
- redness (first appears like a spider bite in most cases)
- sometimes accompanied by fever and chills

Preventing MRSA and other skin disorders

- Avoid contact with infected individuals
- Cover all wounds
- Practice good hygiene: SHOWER with SOAP immediately after EVERY practice/game and do not re-wear sweaty clothing
- Wash practice clothing DAILY
- Do not share clothing
- Clean all equipment - helmets, shoulder pads, wrestling mats, weight equipment, etc. after each use
- Report all skin blemishes/changes to athletic trainer for evaluation
- Prevent getting turf burns
- Wash hands REGULARLY

Treating MRSA

- Requires physician evaluation and prescription for specific type of oral antibiotics and topical cleanser

IT SHOULD BE STRESSED THAT ATHLETES WASH ALL PRACTICE CLOTHING AFTER EACH USE.

ATHLETES SHOULD SHOWER WITH SOAP IMMEDIATELY AFTER PRACTICES AND GAMES.

PLEASE SEE THE SPS BLOOD BORNE PATHOGEN PROTOCOL.

Special Concerns

Allergic Reactions

- If an athlete has an allergic reaction, it is important that he gets medical treatment immediately.
- If the athlete experiences breathing difficulty and and/or if he has an Epi-Pen, get it for them and have him give themselves an injection. Do not do it for them. If they cannot do it themselves, call 9-1-1.
- If the athlete's reaction is minor (hives, itching, irritation, etc.), contact parent. In most cases, a Benadryl will fix the problem but as a coach, you cannot give that medicine to the athlete.

Asthma

- Only athletes who have been diagnosed with asthma should use inhalers;
- Athletes with asthma should only be allowed to use their own inhaler;
- Athletes who use an inhaler often should supply the ATC with one to have at practices/games;
- If trouble persists, **call 9-1-1**.

Dental - Broken Tooth

If an athlete gets a tooth knocked out (or broken off)

- Keep the tooth;
- Put the tooth in a cup of milk (only enough to cover tooth). If milk is unavailable, use water;
- Have athlete chew gum and put over the exposed tooth in mouth (to prevent nerve irritation);
- Send to dentist – don't forget to send the tooth.

Diabetics

Symptoms: rapid onset of altered mental status, intoxicated appearance, elevated heart rate, cold and clammy skin, hunger, seizures, anxiousness

What to Do: Ask the athlete. The athlete will direct you (is he hypoglycemic or hyperglycemic?). Does he want juice? Sugar? Get him what he needs.

Muscle Cramping

- Poor hydration and low electrolyte count is the cause;
- Administer Gatorade or other sports drink;
- Have the athlete chug some mustard (seriously!) and "chase" it with lots of water or Gatorade.

Seizures

- Have athlete lie down. Remove any objects in hand or nearby;
- Loosen restrictive clothing;
- Allow the seizure to finish;
- After the convulsions have ended, protect the airway. If athlete is blue, lift chin and tilt head back.

Call 9-1-1

Sprains and Strains

**DO NOT MOVE ANY ATHLETE WITH A HEAD OR NECK INJURY.
IMMOBILIZE THE HEAD, NECK AND BACK...
CALL 9-1-1**

Ligament Sprains and Muscle Strains:

- Apply ice and compression wrap immediately after injury is sustained. Include a felt or foam horseshoe over the malleolus (ankle bone) on an ankle sprain to help squeeze out severe swelling.
- Ice 3 to 4 times daily for 20 minutes.
- Anti-Inflammatory medication may help (*Ibuprofen, Advil, etc.*)
- Never apply heat to a sprain or strain within the first 48-72 hours after the injury is sustained.

REMEMBER R.I.C.E. → REST, ICE, COMPRESSION, ELEVATION

Shin Splints:

Shin splints are caused by overuse of the lower legs. The pain associated with shin splints is a result of fatigue and trauma to the muscle's tendons where they attach themselves to the tibia. In an effort to keep the foot, ankle and lower leg stable, the muscles exert a great force on the tibia. This excessive force can result in the tendons being partially torn away from the bone.

Causes:

- Exercising on hard surfaces, like concrete;
- Exercising on uneven ground;
- Beginning an exercise program after a long lay-off period;
- Increasing exercise intensity or duration too quickly;
- Exercising in worn out or ill fitting shoes; and
- Excessive uphill or downhill running.

“Cures”:

The best way to treat shin splints is to take appropriate measures to avoid getting them. This includes proper, thorough stretching before and after activity. Wrapping/Taping has not been proven to help shin splints at all (in fact, it can make the condition worse) so the athletic trainers will not tape shin splints. Once an athlete gets shin splints, the best hope is to manage them so they don't turn in to stress fractures. Here are a few tips (other than REST):

- Cold whirlpool treatments each morning with the athletic trainers
- Heat immediately before activity followed by extensive stretching & massage
- Thorough warm up
- Ice after activity
- Ice massage in the evenings
- Ibuprofen to manage swelling and pain (follow bottle's directions)
- Arch supports inside shoes
- Alter training regiment with closed chain activities (bike instead of run)

NEVER apply athletic tape around muscle. This eventually kills muscle cells and places unnecessary stress on bones – potentially causing stress fractures. Only use stretch elastic tape (adhesive) around muscle bellies.

Supplements

The Basics On Nutritional Supplements

Americans spent billions of dollars on sports supplements in 2016, hoping that the pills, drinks, and powders would help them bulk up, slim down, or compete more effectively. But people who take these products are actually conducting what amounts to a vast, uncontrolled clinical experiment on themselves with untested, largely unregulated medications.

The few good scientific studies available on these "dietary" supplements suggest that they either are ineffective or, at best, produce only slight changes in performance. More disturbing, they can contain powerful and potentially harmful substances, such as:

- *Androstenedione*, which can upset the body's hormonal balance when it metabolizes into testosterone and estrogen, and may cause premature puberty and stunted growth in adolescents.
- *Creatine*, a substance produced by the body that can help generate brief surges of muscle energy during certain types of athletic performance. It may also cause kidney problems in susceptible individuals.
- *Ephedra*, an herbal stimulant that acts like an amphetamine ("speed") and that some investigators hold responsible for dozens of deaths and permanent injuries.

Young athletes and other people who want to lose weight or gain energy should not take sports supplements. Evidence for the products' effectiveness is sketchy at best, and concerns about their safety are too numerous. Adults and youngsters alike should focus instead on the basics of fitness and nutrition. Parents who are concerned that their children may be taking any of these supplements should familiarize themselves with some of the most common brand names and ingredients

Creatine-based Supplements

Creatine is a popular nutritional supplement used by athletes to increase muscle mass and strength. The results of continued use of Creatine are similar to those produced by anabolic steroids, however because the supplement is relatively new, research is inconclusive about potential long-term medical side effects. It is known that renal failure, weight gain, and increased potential for muscle strains are potential short-term side effects. Therefore, it is recommended that, if taken, Creatine be used in low to moderate amounts and should not be used as an alternative for a good exercise regimen.

Wound Care

Abrasions & Turf Burns

- Clean affected area thoroughly.
- Clean/Scrub with a 4 in 1 saline solution to make sure any dirt/grass is removed; If using peroxide, dilute to 50% peroxide / 50% saline solution.
- Apply antibiotic ointment (Neosporin);
- Cover with gauze bandage, pre-wrap and soft tape;
- After 2 days, uncover and air dry. The open air will help the wound to scab over;
- Wrap with pre-wrap and soft tape for all participation.

Covering the wound is not enough. It is imperative that the wound is first cleaned thoroughly in order to prevent potentially harmful bacteria

Lacerations

- Apply direct pressure with gauze to stop bleeding;
- Clean the wound thoroughly and irrigate with saline and Betadine;
- Steri-strip, if the bleeding stops;
- If bleeding does not stop and wound is deep (greater than 1/8" deep, cover with pressure bandage and send to physician for evaluation/stitches;
- If wound is caused by object, refer for tetanus.

Blisters

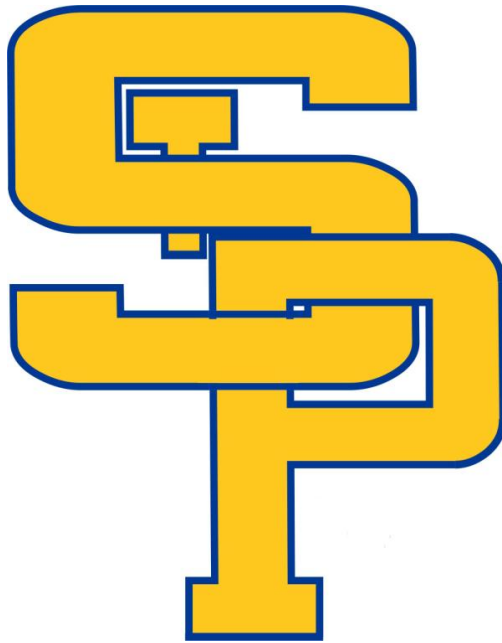
- Clean thoroughly. Irrigate with saline and Betadine;
- Place petroleum jelly pad over blister to avoid continuous rubbing;
- Wrap with pre-wrap and soft tape;
- Watch for inflammation (redness) and warmth, and possibly streaking (long term). These are signs of infection;
- If infection develops, refer to physician immediately for antibiotics.

Never cut away the top skin off a blister if it's soft. The skin helps to provide a protective barrier.

Watch for Shock

- Excessive bleeding can lead to shock. Don't waste time trying to find a dressing;
- Use gloved hand and apply direct pressure over the wound;
- Elevate the extremity;
- Keep applying steady, firm pressure until the bleeding is controlled;
- Once bleeding is controlled, apply a dressing firmly in place (pressure bandage);
- Refer to Emergency Room for further treatment.

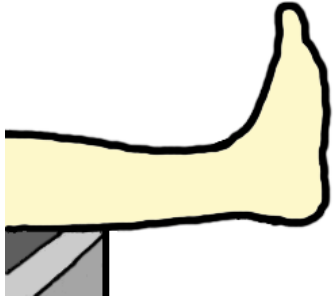
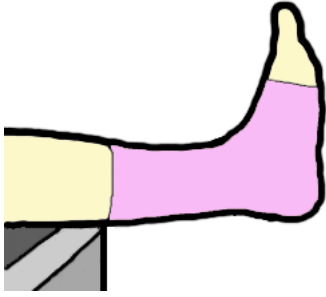
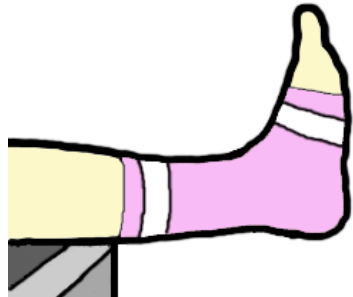
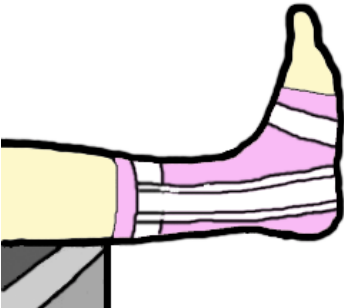
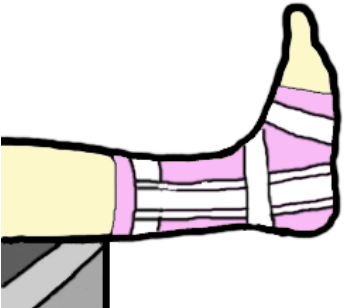
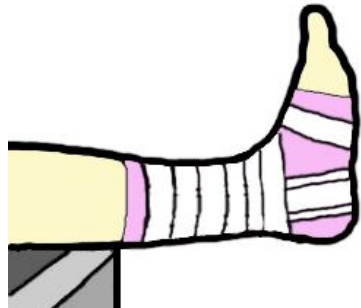
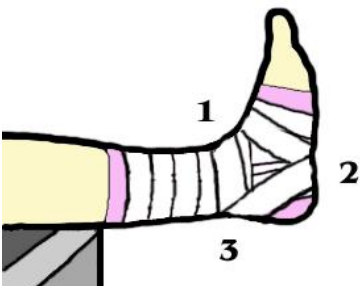
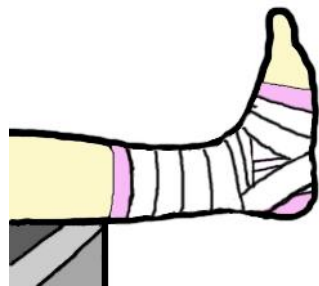
NEVER apply athletic tape around muscle. This eventually kills muscle cells and places unnecessary stress on bones – potentially causing stress fractures. Only use stretch elastic tape (adhesive) around muscle bellies.




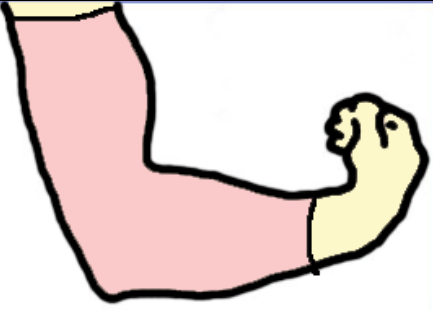
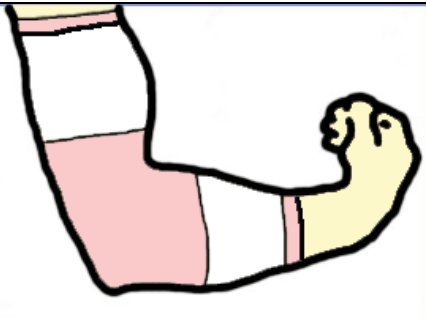

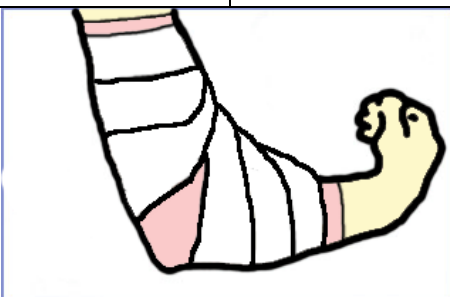
**Part IV:
BASIC TAPING TECHNIQUES FOR SPORT COACHES**

Taping Techniques

Taping the Ankle

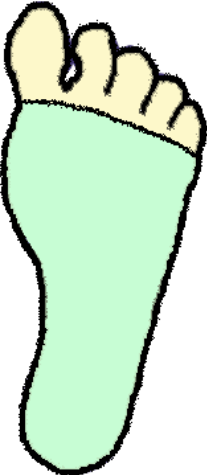
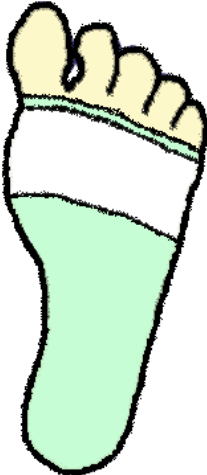
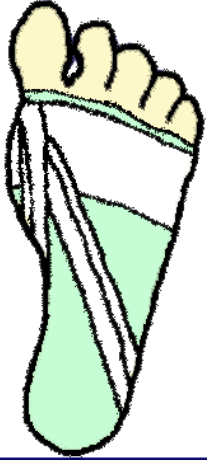
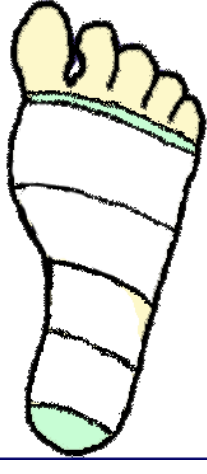
		
<p>Step 1 Place athlete on table. Spray ankle area with adhesive spray. Have athlete pull toe back so foot is at a 90 degree angle and point toes slightly outward.</p>	<p>Step 2 Pre-wrap ankle from mid-calf to just past the mid-foot.</p>	<p>Step 3 Using 2" athletic tape, place anchor strip at the base of the gastrocnemius (calf). Be sure to angle slightly upward (10:00 and 2:00 positions). Place another anchor strip around medial arch on foot – loosely.</p>
		
<p>Step 4 Place 3-5 stirrups longitudinally around ankle joint. Start on inside of foot, pull snug on outside as you fasten at the top.</p>	<p>Step 5 Place 1-3 strips at base of lower leg around ankle joint – just above the heel.</p>	<p>Step 6 Cover stirrups with more strips around lower leg. Be sure to maintain upward angle. Be sure to tear tape after each rotation to avoid circulation problems.</p>
		
<p>Step 7 Apply heel locks. Start tape at 1 (top of ankle), around to 2 (base of heel bone) and around to 3 (back of heel/Achilles' tendon). Then continue to 1– 2– 3 again. Do this 2-4 more times, tearing tape each time. Be careful not to go too low on the foot or too high on the ankle.</p>	<p>Step 8 Place more strips around to secure heel locks. Check for gaps and cover them with strips. Be sure there are no significant folds in tape to avoid blistering or cuts.</p>	

Taping the Elbow

	
<p align="center">Step 1</p> <p>Spray elbow area with adhesive spray. Have athlete flex elbow to 90 degrees, flex bicep and flex wrist. Have the athlete make a tight fist so that forearm muscles are fully flexed.</p>	<p align="center">Step 2</p> <p>Spray elbow area generously with adhesive spray. Pre-wrap from just above the belly of the bicep to just above the wrist.</p>
	
<p align="center">Step 3</p> <p>Using 3" elastic tape, place anchor strips around the entire bicep muscle (you may want to anchor to the skin to ensure the tape job doesn't slide down) to the mid-forearm.</p>	<p align="center">Step 4</p> <p>Using 2" white athletic tape, place 3 stirrups perpendicular to elbow crease from the top anchor strip to the bottom anchor strip. Then, place 3-5 X strips: inside bicep to outside forearm; outside bicep to inside forearm.</p>
	
<p align="center">Step 5</p> <p>Using 3" elastic tape, cover entire area. Be sure not to make the tape too tight. Be sure athlete continues to have bicep, wrist and fist fully flexed to avoid circulation issues.</p>	

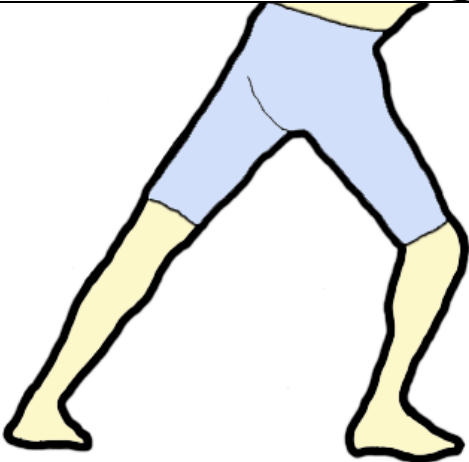
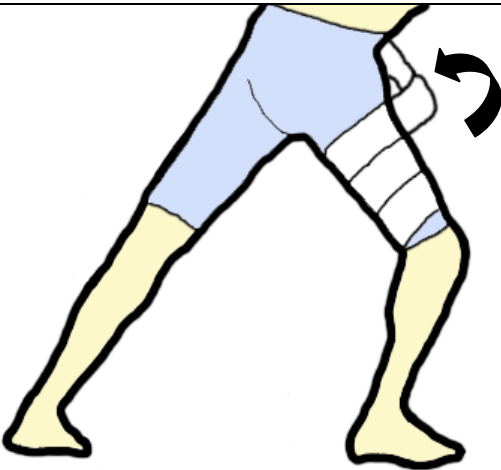
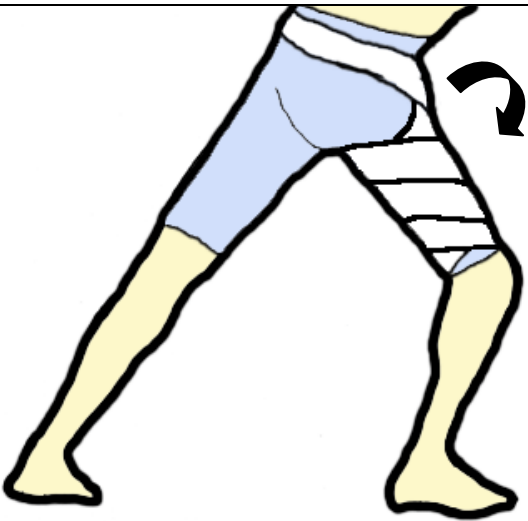
NEVER USE STANDARD WHITE ATHLETIC TAPE TO GO AROUND MUSCLE. Without the elasticity, muscle cell dies and strength is significantly reduced.

Taping the Arch

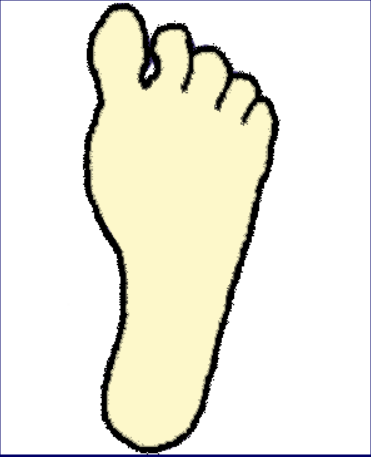

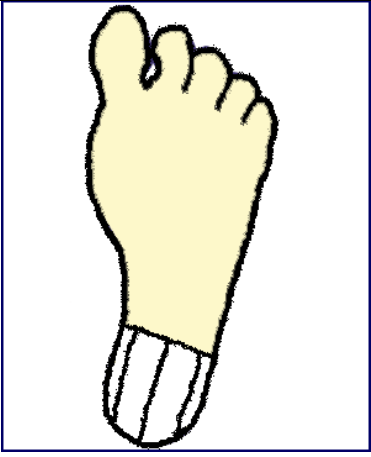
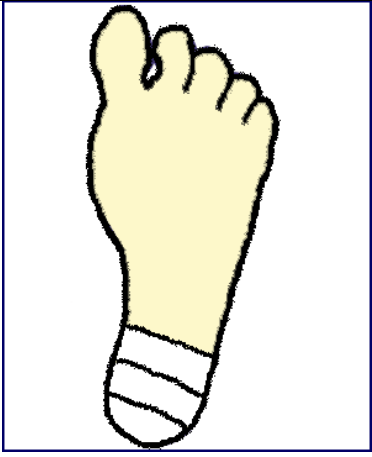
	
<p align="center">Step 1</p> <p>Place athlete on table. Spray bottom of foot generously with adhesive spray. Allow 1-2 minutes to dry. Pre-wrap entire foot and heel area. You will anchor the pre-wrap over the ankle joint.</p>	<p align="center">Step 2</p> <p>Using 3" elastic soft tape, apply one single rotation of tape around the ball of the foot just below the toes. Be sure not to pull the tape very tight, but also don't leave it too loose.</p>
	
<p align="center">Step 3</p> <p>Using a split roll of 2" white athletic tape, you will now apply teardrop strips. Starting above the ball of the great toe, apply the tape down across the foot and behind the heel. Work the tape around the back of the heel and back up across the arch. Tear the tape over the top of the original starting position. Apply 3-4 teardrops.</p>	<p align="center">Step 4</p> <p>Once the teardrops are in place, cover the entire foot with 3" soft elastic tape. You will want to apply a basic heel lock (see ankle tape) to ensure the tape job stays in tact during athletic participation.</p>

For athletes with arch and ankle problems, tape the arch first and then tape the ankle.

Taping the Groin

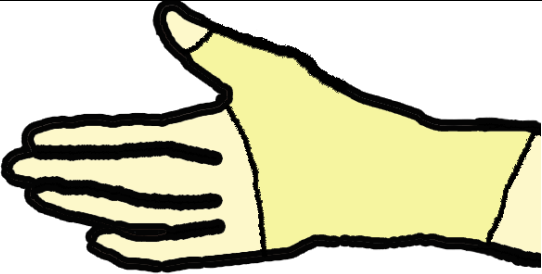
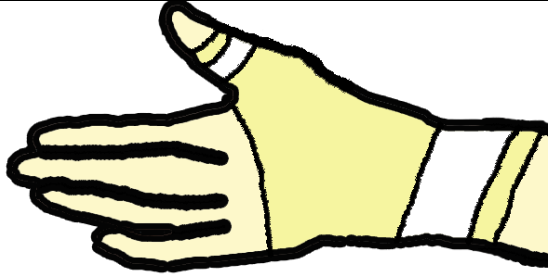


	<p>Step 1</p> <p>Have the athlete strip down to compression shorts or underwear. Then, ask the athlete to put majority of his or her weight on the affected leg with the knee bent to 35-50 degrees.</p>
	<p>Step 2</p> <p>Using a double-length, elastic bandage (ACE wrap or 3" soft elastic tape), begin the wrap just above the knee and work upwards and diagonally up the thigh. Pull tension on the inside of the leg ("pull and then wrap"). Overlap half of the width of the elastic wrap. Once you cover the groin area, angle the wrap above the opposite hip bone and behind and around the waist....</p>
	<p>Step 3</p> <p>Once you come around the waist, cover the hip bone of the affected leg and reverse the direction of the elastic wrap back down the thigh. Secure the wrap once you get back down to the knee. Be certain there are no visible gaps and that the wrap does not have any weak areas.</p> <p>If using an ACE wrap, you will want to secure the end points with 3" elastic tape.</p>

Taping the Heel

	
<p>Step 1 Place athlete on table. Spray bottom of heel area generously with adhesive spray. Allow 1-2 minutes for adhesive spray to completely dry. Area will be very sticky. You are <u>not</u> using pre-wrap.</p>	<p>Step 2 Using 2" white athletic tape, apply 3-4 strips on the bottom of the heel. Pull tension on both sides of the tape. Each strip should run the width of the heel and will anchor approximately ½ to 1 inch on the inside and outside of the leg.</p>
	
<p>Step 3 Again, using 2" white athletic tape, apply 3-4 strips on the bottom of the heel. This time, the strips should be perpendicular to the previous strips. Pull tension on the back of the heel. These strips will anchor at the front of the heel and approximately ½ to 1 inch on the back of the heel (Achilles' tendon)</p>	<p>Step 4 Apply another 3-4 strips on the bottom of the heel perpendicular again to the previous strips. Pull tension on both sides of the tape.</p>







This is an excellent tap job for bruised or sore heels.

Taping the Thumb

	
<p style="text-align: center;">Step 1</p> <p>Have the athlete put the hand forward – as if to shake your hand. The athlete should have his/her thumb in a neutral position. Apply adhesive spray generously to thumb and wrist areas. Pre-wrap thumb, hand and wrist.</p>	<p style="text-align: center;">Step 2</p> <p>Using 2" white athletic tape, apply anchor strip to wrist. Be sure you are laying the tape evenly over the wrist to avoid circulation issues later on. Split the 2" roll of tape and apply 1" wide anchor strip around thumb just below the middle knuckle.</p>
	
<p style="text-align: center;">Step 3</p> <p>Continuing to use the split roll of white athletic tape, you will now form the thumb spica. Anchor the end of the strip on the back of the wrist and angle the strip around the palm, to the inside of the thumb and that back to the inside of the wrist. Tear the tape. Repeat these spica strips until you cover the entire base of the thumb (where the thumb meets the wrist). For additional support (but less mobility), go higher on the thumb. Be sure to overlap the tap by half of its width.</p>	<p style="text-align: center;">Step 4</p> <p>Using 2" white athletic tape, apply anchor strip to wrist. Be sure you are laying the tape evenly over the wrist to avoid circulation issues later on. Split the 2" roll of tape and apply 1" wide anchor strip around thumb just below the middle knuckle.</p>

For even more support (including additional wrist support), you can run a strip through the hand.

Taping the Wrist

		
<p>Step 1 Have athlete spread hand and fingers wide. You want to make sure all muscles are contracted and tight. After spraying with adhesive, pre-wrap area from lower arm (just above the wrist) to the hand.</p>	<p>Step 2 Using 2" white athletic tape, apply one continuous strip around the wrist, through the hand, and back around the wrist. Be sure not to apply the tape too tightly around the crease between the thumb and the hand.</p>	<p>Step 3 You will now apply stirrup strips. The first is one straight stirrup from the palm side of the hand through the wrist. Apply slight flexion to the wrist.</p>
		
<p>Step 4 The next stirrup should run from the thumb side of the palm to the inside of the wrist. Be sure to maintain slight flexion of the wrist.</p>	<p>Step 5 The final stirrup should run from the inside of the palm (pinky finger) to the outside of the wrist. For added support, you may repeat steps 3-5 and/or increase wrist flexion when you apply the stirrups.</p>	<p>Step 6 Continuing with your 2" white athletic tape, apply one continuous strip again around the wrist 2-3 times, through the hand, and back around the wrist. Be sure the athlete keeps the hand and fingers flexed to avoid circulation problems.</p>

For wrist flexion injuries, place the stirrups on the back side of the hand with the wrist hyper-extended.



**Part V:
DEALING WITH SPORT EMERGENCIES AT ST PAUL'S SCHOOL**

St. Paul's School Emergency Action Plan Heap Field (Baseball)

Emergency Personnel: Athletic Trainer, Head Coach, Assistant Coaches, Athletic Director, School Administrators

Emergency Communication: The Certified Athletic Trainer and Athletic Director will carry cellular telephones. We recommend the head coach of each of the teams carry a cellular phone, in case of emergency.

Emergency Equipment: Supplies stored in Training Room include trauma kit, splint kit, crutches, wheelchairs, various wound care necessities, and any other items deemed necessary by the team's physician.

Roles of Certified Athletic Trainer (ATC)

- Preventative care for all student-athletes (includes evaluation, consultation, taping, and hot and cold therapy);
- Immediate evaluation and care of the more seriously-injured or ill student-athletes;
 - Activation of emergency medical system (EMS);
 - 911 call (provide name, address, telephone number; number of individuals injured; condition of injured; first aid treatment; specific directions; other information as requested);
- Return to play decision-making on the injured student-athlete;
- Physician referral of the injured student-athlete;
- Contacting the parent(s) of the injured student-athlete;
- Rehabilitative care for injured student-athletes (includes evaluation, consultation, taping, and use of hot and cold therapy. Rehabilitation should follow physician protocols.

Roles of Coaches

- Direct EMS personnel (ambulance) to scene;
- Unlock and open gate between school and practice fields;
- designate individual to "flag down" EMS and direct to scene;
- Scene control: limit scene to sports medicine personnel and move bystanders (including players) away from area.

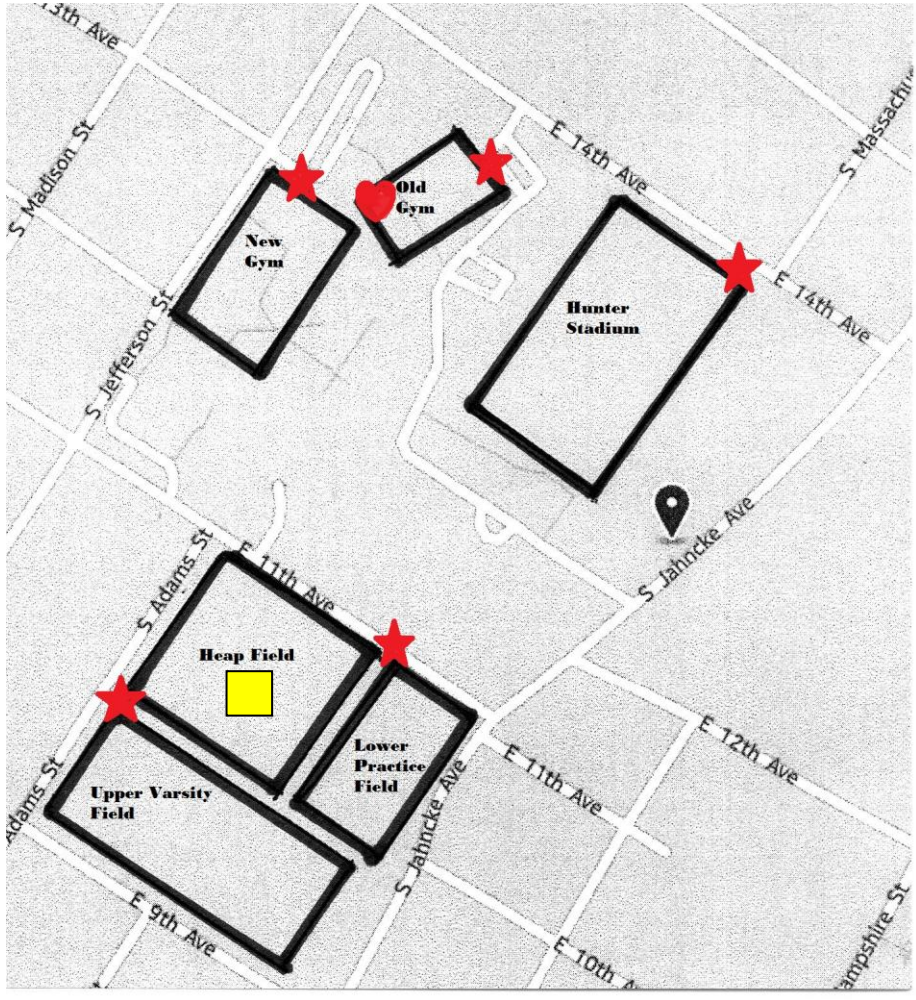
Roles of Administrative Staff


- Ensure emergency entrance to facility is clear and accessible (check parking lots regularly);
- Unlock and open doors for EMS to access gym;
- Direct EMS personnel (ambulance) to scene (in the event there are no student trainers present);
- Scene control: limit scene to sports medicine personnel and move bystanders (including other athletes) away from area of injured athlete.

Venue Directions:

Heap Field: located at the corner of S. Adams St. and E 11th Ave.

Venue Map: *Heap Field (Baseball)*



 = Venue

 = Ambulance Entry Point

 = AED Location (in Athletic Training Room or on Site for Games)

St. Paul's School Emergency Action Plan New Gymnasium (Basketball and Wrestling)

Emergency Personnel: Athletic Trainer, Head Coach, Assistant Coaches, Athletic Director, School Administrators

Emergency Communication: The Certified Athletic Trainer and Athletic Director will carry cellular telephones. We recommend the head coach of each of the teams carry a cellular phone, in case of emergency.

Emergency Equipment: Supplies and equipment brought to gym for games include taping and bracing supplies, general trauma and wound care kits.

Roles of Certified Athletic Trainer (ATC)

- Preventative care for all student-athletes (includes evaluation, consultation, taping, and hot and cold therapy);
- Immediate evaluation and care of the more seriously-injured or ill student-athletes;
 - Activation of emergency medical system (EMS);
 - 911 call (provide name, address, telephone number; number of individuals injured; condition of injured; first aid treatment; specific directions; other information as requested);
- Return to play decision-making on the injured student-athlete;
- Physician referral of the injured student-athlete;
- Contacting the parent(s) of the injured student-athlete;
- Rehabilitative care for injured student-athletes (includes evaluation, consultation, taping, and use of hot and cold therapy). Rehabilitation should follow physician protocols.

Roles of Coaches

- Immediate evaluation and care of the more seriously-injured or ill student-athletes;
 - 911 call (provide name, address, telephone number; number of individuals injured; condition of injured; first aid treatment; specific directions; other information as requested);
 - Contacting the parent(s) of the injured student-athlete;
- Direct individual to direct EMS personnel (ambulance) to scene;
- Scene control: limit scene to sports medicine personnel and move bystanders (including players) away from area. Preventative care for all student-athletes athletes (includes evaluation, consultation, taping, and hot and cold therapy).

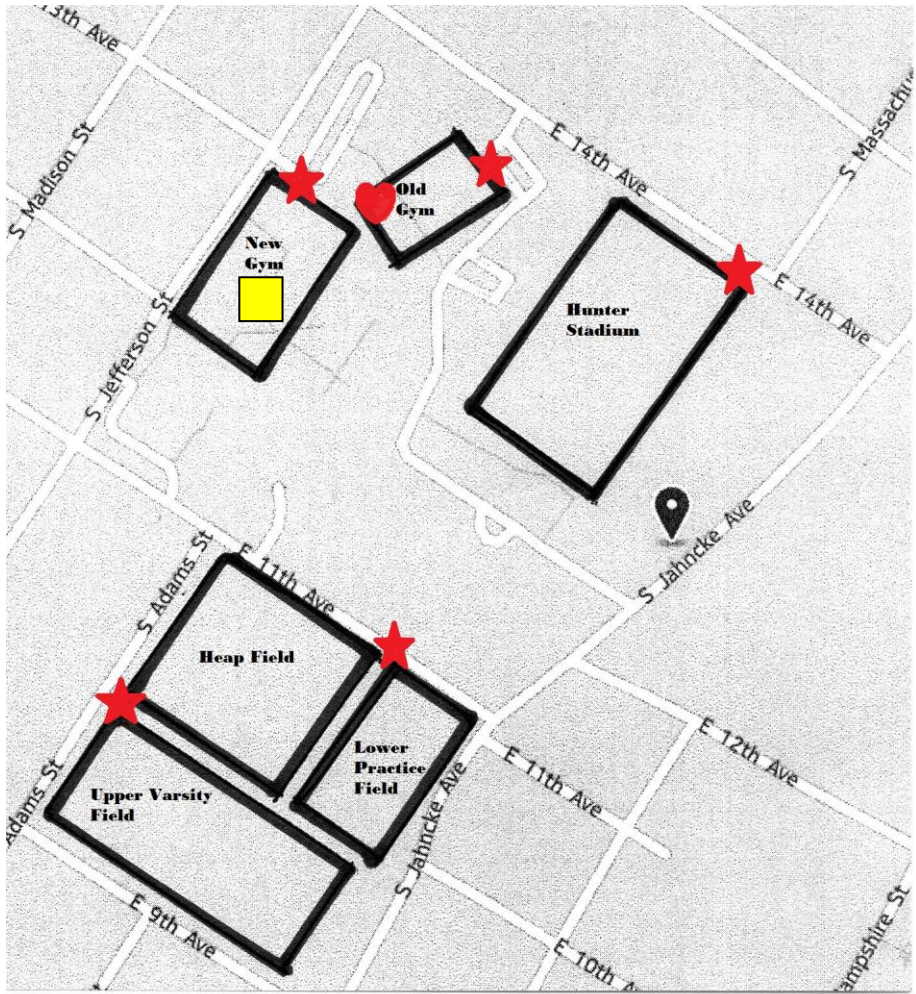
Roles of Administrators/Coaches

- Ensure emergency entrance to facility is clear and accessible (check parking lots regularly);
- Unlock and open doors for EMS to access gym;
- Direct EMS personnel (ambulance) to scene (in the event there are no student trainers present);
- Scene control: limit scene to sports medicine personnel and move bystanders (including other athletes) away from area of injured athlete.

Venue Directions:

New Gymnasium: located on S. Jefferson Ave. between W. 13th Ave. and W. 12th Ave.

Venue Map: *New Gymnasium (Basketball and Wrestling)*



= Venue



= Ambulance Entry Point



= AED Location (in Athletic Training Room or on Site for Games)

St. Paul's School Emergency Action Plan Hunter Stadium (Football, Soccer, Track, Cross Country & Lacrosse)

Emergency Personnel: Athletic Trainer, Head Coach, Assistant Coaches, Athletic Director, School Administrators

Emergency Communication: The Certified Athletic Trainer and Athletic Director will carry cellular telephones. We recommend the head coach of each of the teams carry a cellular phone, in case of emergency.

Emergency Equipment: supplies and equipment brought to gym for games include taping and bracing supplies, general trauma and wound care kits.

Roles of Certified Athletic Trainer (ATC)

- Preventative care for all student-athletes (includes evaluation, consultation, taping, and hot and cold therapy);
- Immediate evaluation and care of the more seriously-injured or ill student-athletes;
 - Activation of emergency medical system (EMS);
 - 911 call (provide name, address, telephone number; number of individuals injured; condition of injured; first aid treatment; specific directions; other information as requested);
- Return to play decision-making on the injured student-athlete;
- Physician referral of the injured student-athlete;
- Contacting the parent(s) of the injured student-athlete;
- Rehabilitative care for injured student-athletes (includes evaluation, consultation, taping, and use of hot and cold therapy. Rehabilitation should follow physician protocols.

Roles of Coaches

- Immediate evaluation and care of the more seriously-injured or ill student-athletes;
 - 911 call (provide name, address, telephone number; number of individuals injured; condition of injured; first aid treatment; specific directions; other information as requested);
 - Contacting the parent(s) of the injured student-athlete;
- Direct individual to direct EMS personnel (ambulance) to scene;
- Scene control: limit scene to sports medicine personnel and move bystanders (including players) away from area. Preventative care for all student-athletes athletes (includes evaluation, consultation, taping, and hot and cold therapy).

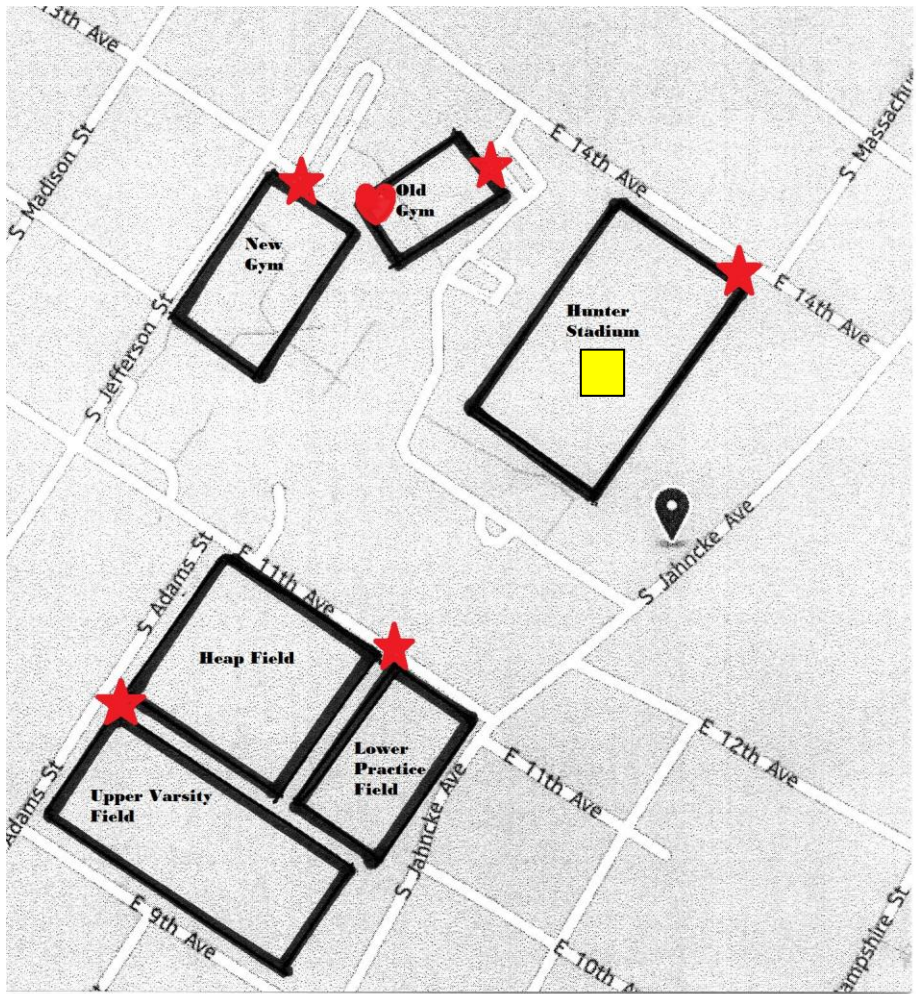
Roles of Administrators/Coaches


- Ensure emergency entrance to facility is clear and accessible (check parking lots regularly);
- Unlock and open doors for EMS to access field;
- Direct EMS personnel (ambulance) to scene (in the event there are no student trainers present);
- Scene control: limit scene to sports medicine personnel and move bystanders (including other athletes) away from area of injured athlete.

Venue Directions:

Hunter Stadium: located on E. 14th Ave. near the intersection of S. Massachusetts St.

Venue Map: Hunter Stadium (Football, Soccer, Track, Cross Country & Lacrosse)



 = Venue

 = Ambulance Entry Point

 = AED Location (in Athletic Training Room or on Site for Games)

St. Paul's School Emergency Action Plan Old Gymnasium (Wrestling)

Emergency Personnel: Athletic Trainer, Head Coach, Assistant Coaches, Athletic Director, School Administrators

Emergency Communication: The Certified Athletic Trainer and Athletic Director will carry cellular telephones. We recommend the head coach of each of the teams carry a cellular phone, in case of emergency.

Emergency Equipment: supplies and equipment brought to gym for games include taping and bracing supplies, general trauma and wound care kits.

Roles of Certified Athletic Trainer (ATC)

- Preventative care for all student-athletes (includes evaluation, consultation, taping, and hot and cold therapy);
- Immediate evaluation and care of the more seriously-injured or ill student-athletes;
 - Activation of emergency medical system (EMS);
 - 911 call (provide name, address, telephone number; number of individuals injured; condition of injured; first aid treatment; specific directions; other information as requested);
- Return to play decision-making on the injured student-athlete;
- Physician referral of the injured student-athlete;
- Contacting the parent(s) of the injured student-athlete;
- Rehabilitative care for injured student-athletes (includes evaluation, consultation, taping, and use of hot and cold therapy. Rehabilitation should follow physician protocols.

Roles of Coaches

- Immediate evaluation and care of the more seriously-injured or ill student-athletes;
 - 911 call (provide name, address, telephone number; number of individuals injured; condition of injured; first aid treatment; specific directions; other information as requested);
 - Contacting the parent(s) of the injured student-athlete;
- Direct individual to direct EMS personnel (ambulance) to scene;
- Scene control: limit scene to sports medicine personnel and move bystanders (including players) away from area. Preventative care for all student-athletes athletes (includes evaluation, consultation, taping, and hot and cold therapy).

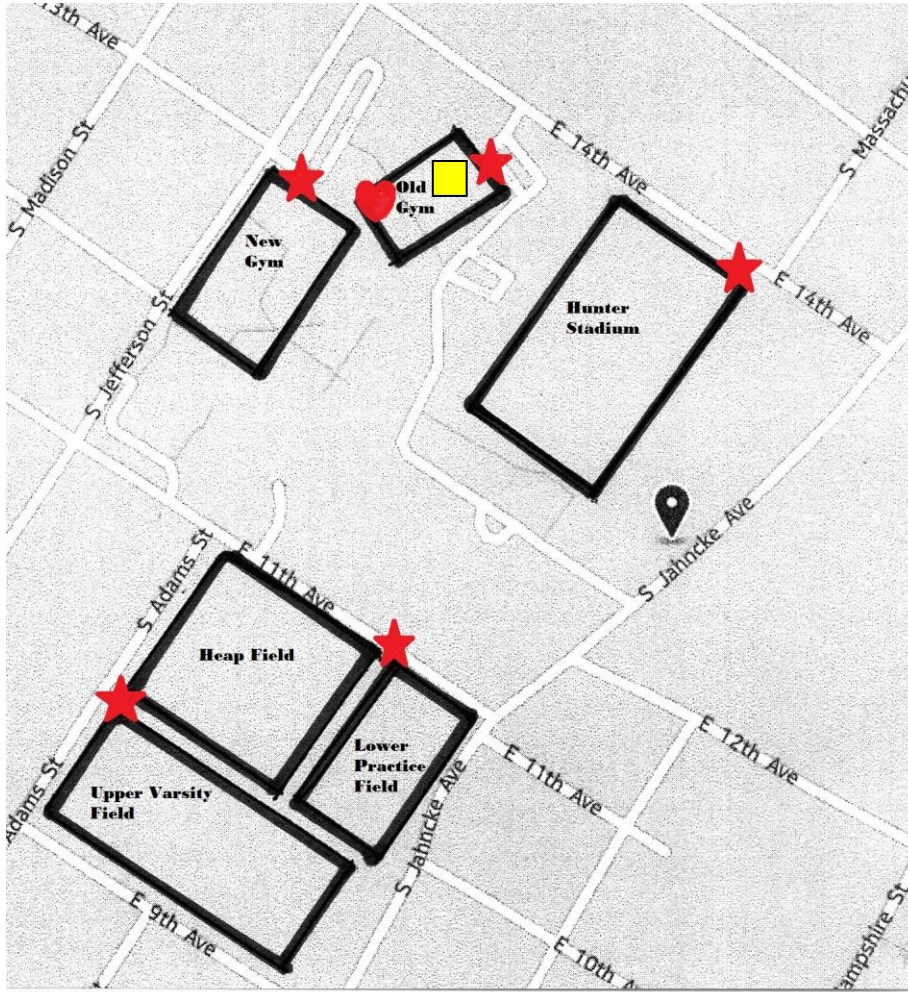
Roles of Administrators/Coaches


- Ensure emergency entrance to facility is clear and accessible (check parking lots regularly);
- Unlock and open doors for EMS to access gym;
- Direct EMS personnel (ambulance) to scene (in the event there are no student trainers present);
- Scene control: limit scene to sports medicine personnel and move bystanders (including other athletes) away from area of injured athlete.

Venue Directions:

Old Gymnasium: located at the intersection of De La Salle Dr. and E. 14th Ave.

Venue Map: Old Gymnasium (Wrestling)



 = Venue

 = Ambulance Entry Point

 = AED Location (in Athletic Training Room or on Site for Games)

St. Paul's School Emergency Action Plan Upper Varsity Field (Baseball & Soccer)

Emergency Personnel: Athletic Trainer, Head Coach, Assistant Coaches, Athletic Director, School Administrators

Emergency Communication: The Certified Athletic Trainer and Athletic Director will carry cellular telephones. We recommend the head coach of each of the teams carry a cellular phone, in case of emergency.

Emergency Equipment: supplies stored in Training Room include trauma kit, splint kit, crutches, wheelchairs, various wound care necessities, and any other items deemed necessary by the team's physician.

Roles of Certified Athletic Trainer (ATC)

- Preventative care for all student-athletes (includes evaluation, consultation, taping, and hot and cold therapy);
- Immediate evaluation and care of the more seriously-injured or ill student-athletes;
 - Activation of emergency medical system (EMS);
 - 911 call (provide name, address, telephone number; number of individuals injured; condition of injured; first aid treatment; specific directions; other information as requested);
- Return to play decision-making on the injured student-athlete;
- Physician referral of the injured student-athlete;
- Contacting the parent(s) of the injured student-athlete;
- Rehabilitative care for injured student-athletes (includes evaluation, consultation, taping, and use of hot and cold therapy. Rehabilitation should follow physician protocols.

Roles of Coaches

- Direct EMS personnel (ambulance) to scene;
- Unlock and open bar gate between school and practice fields;
- designate individual to "flag down" EMS and direct to scene;
- Scene control: limit scene to sports medicine personnel and move bystanders (including players) away from area.

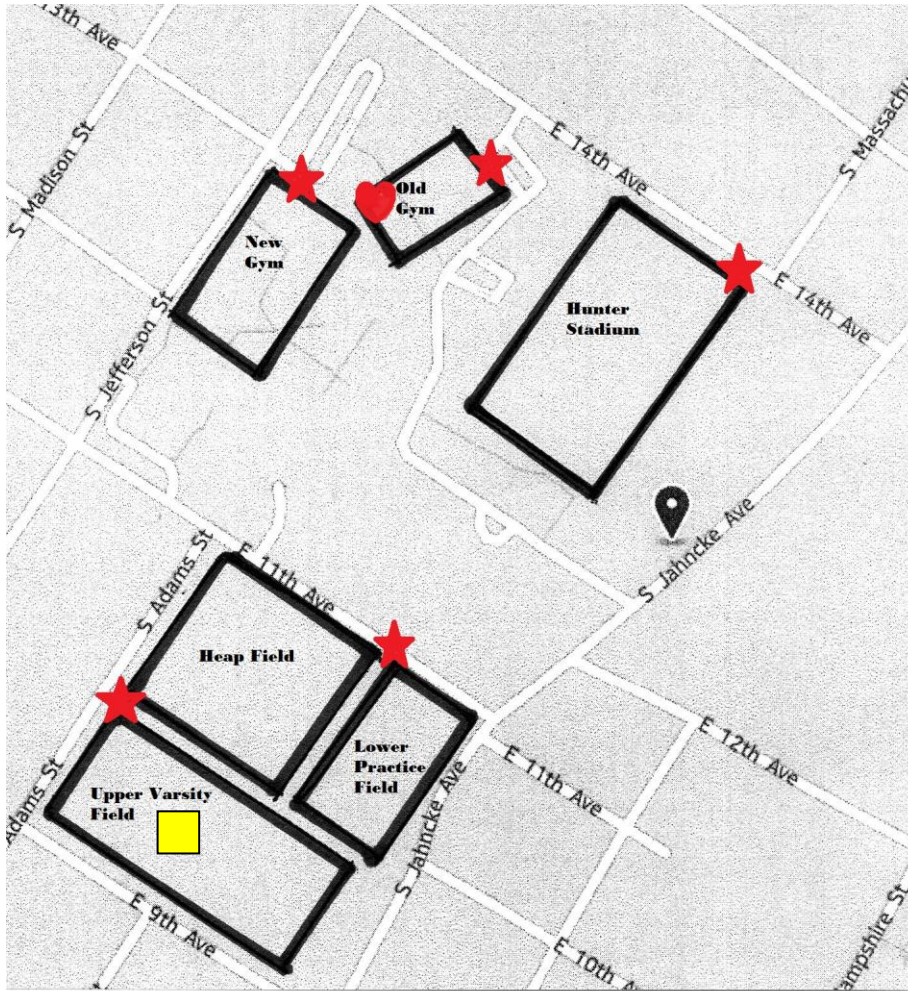
Roles of Administrative Staff


- Ensure emergency entrance to facility is clear and accessible (check parking lots regularly);
- Unlock and open doors for EMS to access gym;
- Direct EMS personnel (ambulance) to scene (in the event there are no student trainers present);
- Scene control: limit scene to sports medicine personnel and move bystanders (including other athletes) away from area of injured athlete.

Venue Directions:

Upper Varsity Field: located at the intersection of S. Adams St. and E. 19th Ave.

Venue Map: Upper Varsity Field (Baseball & Soccer)



 = Venue

 = Ambulance Entry Point

 = AED Location (in Athletic Training Room or on Site for Games)

St. Paul's School Emergency Action Plan Lower Practice Field (Soccer & Football)

Emergency Personnel: Athletic Trainer, Head Coach, Assistant Coaches, Athletic Director, School Administrators

Emergency Communication: The Certified Athletic Trainer and Athletic Director will carry cellular telephones. We recommend the head coach of each of the teams carry a cellular phone, in case of emergency.

Emergency Equipment: supplies stored in Training Room include trauma kit, splint kit, crutches, wheelchairs, various wound care necessities, and any other items deemed necessary by the team's physician.

Roles of Certified Athletic Trainer (ATC)

- Preventative care for all student-athletes (includes evaluation, consultation, taping, and hot and cold therapy);
- Immediate evaluation and care of the more seriously-injured or ill student-athletes;
 - Activation of emergency medical system (EMS);
 - 911 call (provide name, address, telephone number; number of individuals injured; condition of injured; first aid treatment; specific directions; other information as requested);
- Return to play decision-making on the injured student-athlete;
- Physician referral of the injured student-athlete;
- Contacting the parent(s) of the injured student-athlete;
- Rehabilitative care for injured student-athletes (includes evaluation, consultation, taping, and use of hot and cold therapy. Rehabilitation should follow physician protocols.

Roles of Coaches

- Direct EMS personnel (ambulance) to scene;
- Unlock and open bar gate between school and practice fields;
- designate individual to "flag down" EMS and direct to scene;
- Scene control: limit scene to sports medicine personnel and move bystanders (including players) away from area.

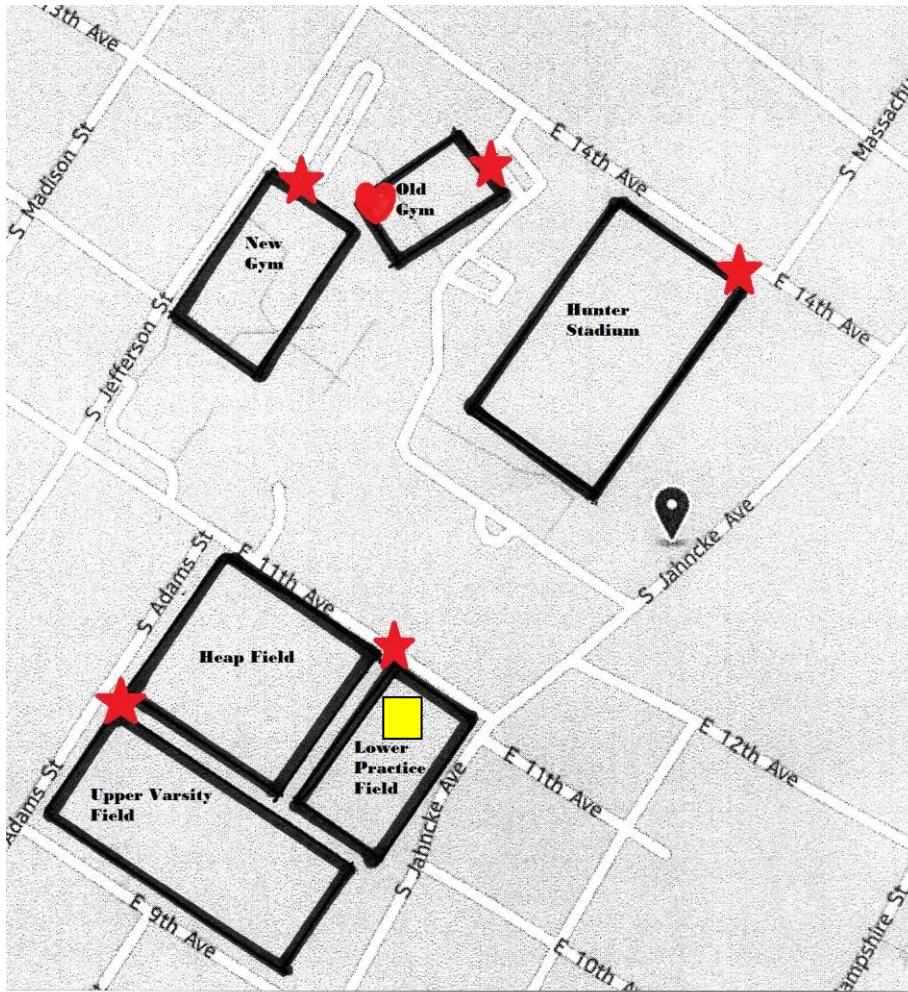
Roles of Administrative Staff


- Ensure emergency entrance to facility is clear and accessible (check parking lots regularly);
- Unlock and open doors for EMS to access gym;
- Direct EMS personnel (ambulance) to scene (in the event there are no student trainers present);
- Scene control: limit scene to sports medicine personnel and move bystanders (including other athletes) away from area of injured athlete.

Venue Directions:

Lower Practice Field: located at the intersection of S. Jahncke Ave. and E. 11th Ave.

Venue Map: Lower Practice Field (Soccer & Football)



 = Venue

 = Ambulance Entry Point

 = AED Location (in Athletic Training Room or on Site for Games)



**ST. PAUL'S SCHOOL EMERGENCY ACTION PLAN FOR ATHLETICS
PROTOCOLS, POLICIES & PROCEDURES**

ST. PAUL'S SCHOOL EMERGENCY ACTION PLAN FOR ATHLETICS
Emergency Contacts

Emergency Medical Services	9-1-1
Covington Police Department – Dispatch	985-892-8500
Covington Fire Department – Dispatch	985-892-4242
St. Tammany Parish Hospital – Emergency Dept.	985-898-4000
Lakeview Regional Medical Center – Emergency Dept.	985-867-3800
Craig Ketelsen, Athletic Director – cellular phone	985-966-1147
Trevor Watkins, Principal – cellular phone	985-249-1581
Chris Stipe, Athletic Trainer – cellular phone	985-789-4105
St. Paul's School – Main Office	985-892-3200



Sports Medicine

Heat Safety Protocol

Emergency Phone Numbers:

Chris Stipe, Head Athletic Trainer: 985-789-4105

Craig Ketelsen, Athletic Director: 985-966-1147

The athletic training staff will evaluate conditions by direct measurement on site with the use of an automated heat index monitor. This is done before practice and as conditions warrant. Temperature and relative humidity conditions will be posted and updated for all coaches along with the below practice guidelines. Athletic trainers will keep a log record of temperature and humidity during times of extreme conditions.

The following scale is used to determine what limitations are imposed on athletic activities. In game situations, the ATC on duty will make decisions regarding heat and humidity with the officials and coaches.

Relative Humidity	Air Temperature	Practice
Under 70%	Under 89°	No limitations.
Over 70% Under 70%	80° - 89° OR 90° - 99°	Shortened practices with water breaks (football-minimum pads).
Over 70%	90° - 99°	Restricted practice with numerous water breaks as defined by athletic trainer, coach and administrator consultation.
(Any Value)	100°+	Suspend practice.

Athletes will be instructed to remove themselves from any athletic activity if they feel overheated. If an athlete has any symptoms of heat related illness (see signs and symptoms below), he/she will be removed from any athletic activity and given reasonable and prudent immediate care by the training and/or coaching staff. The athlete's parent/guardian will be notified and advised to contact their physician or go to the local emergency room if symptoms persist or worsen.

Athletes with any heat related illness (see signs and symptoms below) would be reevaluated by the Certified Athletic Trainer before being allowed to return to activity. The coach will verify the athletes practice status with the athletic trainer prior to the athlete returning to activity.

The principal, associate principals, and athletic director will be notified of practice limitations and are responsible for monitoring the adherence to these guidelines.

Heat Related Illness: Signs and Symptoms

Heat Cramps	Involuntary muscle spasm (usually located in, but not limited, to calves).
Heat exhaustion	Throbbing headache, nausea, vomiting, chills, dizziness or lightheadedness, rapid pulse, cool and clammy skin, pale skin color, and/or excessive sweating.
Heat Stroke (Medical Emergency)	Disorientation, slurred speech, confusion or aggressive behavior, unconsciousness, dry skin (absence of sweat is highly suggestive of heat related illness but sweating may be present as well), flushed/hot skin, rapid/pounding pulse.

I. Prevention of Heat Related Illness

- a. Allow unlimited access to water/fluids at all practices and games.
- b. Watch players who have a high body fat; have to work harder for same results.
- c. Watch players who have smaller bodies because they have less surface area to get rid of heat.
- d. Watch the very young - prepubertal; sweating mechanism not fully developed until then.
- e. Watch those with more clothing/equipment; the heat is trapped against their bodies.
- f. Encourage athletes to drink fluids at same rate that they lost them (work hard, drink a lot).

- g. Talk to athletes and coaches in preseason about prevention of heat illness (Gatorade video).
- h. Discourage weight loss if it is only fluid loss (wrestlers, etc.).
- i. Check urine; dark, concentrated urine means dehydrated, clear means hydrated.
- j. Those athletes who are in poor physical condition are at higher risk. For example, the ones who did not do summer school sports are at greater risk in the fall.
- k. Athletes who have been ill, have a fever, or are recovering from an illness are at greater risk.

II. Fluid Replacement

- a. Athletes must drink past the point where their thirst is quenched.
- b. Fluids should be available freely to all athletes at all times.
- c. Athletes must replenish fluids to the weight they were before practice.
- d. Athletes should check their urine color before practice; if it is dark; they are still dehydrated and should drink before practice.
- e. Cold water is an excellent replacement fluid.
- f. Fluids other than water:
 1. Sports drinks are generally only necessary during long-term activities. They help replenish sugar and minerals lost in sweat. However, they are not harmful at any time.
 2. Avoid drinks high in sugar (sodas) due to slow absorption.
 3. Avoid drinks high in caffeine: tea, sodas, and coffee. They cause urination.



Sports Medicine

Lightning Safety Protocol

Emergency Phone Numbers:

Chris Stipe, Head Athletic Trainer: 985-789-4105

Craig Ketelsen, Athletic Trainer: 985-966-1147

Lightning Safety Policy is based on:

**1. The National Athletic Trainers' Association Position Statement:
Lightning Safety for Athletics and Recreation.**

2. The NCAA Position Statement on Lightning Safety.

In the event of severe weather, when threatening lightning conditions are probable, at least one of the following two indicators of lightning location will be used as the recognized method of determining dangerous lightning situations:

1. SkyScan Lightning detector:

2. Flash to Bang counting method:

*Flash to Bang method of determining proximity of lightning activity:

1. When lightning is noticed begin counting.

2. Counting is stopped once the associated thunder (bang) is heard.

3. Divide this count by 5 to determine the distance to the lightning flash (in miles). Ex: a flash to bang count of 30 seconds equates to a distance of 6 miles.

****Lightning has been reported to strike 10 miles or more from where it originated.***

By these methods, once lightning conditions are detected within 6 – 8 miles of the practice or event site, activity will have been suspended and all individuals will have been moved to a safe shelter. Return to the activity site will not resume until 30 minutes following the last indication of lightning conditions within the 6-8 mile range.

During practice, the athletic trainer on site will inform the head coach of threatening lightning conditions. If an athletic trainer is not on site, the head coach will assume responsibility of monitoring threatening lightning conditions and immediately instructing the athletes to proceed to the closest, safe, shelter.

During home events the athletic trainer on site will inform the officials and coaches of threatening lightning conditions and that play is to be suspended. At the start of every athletic competition, the ATC will make coaches and game officials aware of the lightning safety protocol.

**All individuals have the right to leave an athletic site or activity, without fear of repercussion or penalty, in order to seek a safe structure or location if they feel they are in danger from impending lightning activity. Individuals who feel their hair stand on end or skin tingle or hear crackling noises should assume the lightning–safe position (i.e., crouched on the ground, weight on the balls of the feet, feet together, head lowered, and ears covered). Do not lie flat on the ground.*

****Open shelters, dugouts, golf carts, and similar structures are NOT safe locations from lightning hazards. In any structure during a lightning storm, all electrical conducting materials that are exposed to lightning are potentially unsafe and should be avoided: i.e. plumbing fixtures and pipelines, land line telephones, and electrical appliances.***



Sports Medicine

Helmet Removal Protocol

General Guidelines:

- Any athlete suspected of having a spinal injury should not be moved and should be managed as though a spinal injury exists.
- The athlete's airway, breathing and circulation, neurological status and level of consciousness should be assessed.
- The athlete should not be moved unless absolutely essential to maintain airway, breathing and circulation.
- If the athlete must be moved to maintain airway, breathing and circulation, the athlete should be placed in a supine position while maintaining spinal immobilization.
- When moving a suspected spine injured athlete, the head and trunk should be moved as a unit. One accepted technique is to manually splint the head to the trunk.
- The Emergency Medical Services system should be activated.

Face Mask Removal:

- The facemask should be removed with a cordless screwdriver prior to transportation, regardless of current respiratory status.
- Those involved in the pre-hospital care of injured football players should have the tools (cordless screwdriver) for facemask removal readily available.

Football Helmet Removal:

The athletic helmet and chinstrap should only be removed...

- if the helmet and chin strap do not hold the head securely, such that immobilization of the helmet does not also immobilize the head.
- if the design of the helmet and chin strap is such that even after removal of the facemask the airway cannot be controlled, or ventilation be provided.
- if the facemask cannot be removed after a reasonable period of time.
- if the helmet prevents immobilization for transportation in an appropriate position.

Helmet Removal:

Spinal immobilization must be maintained while removing the helmet.

- Helmet removal should be frequently practiced under proper supervision.
- Specific guidelines for helmet removal need to be developed.
- In most circumstances, it may be helpful to remove cheek padding and/or deflate air padding prior to helmet removal.

Equipment:

Appropriate spinal alignment must be maintained.

- There needs to be a realization that the helmet and shoulder pads elevate an athlete's trunk when in the supine position.
- Should either be removed, or if only one is present, appropriate spinal alignment must be maintained.
- The front of the shoulder pads can be opened to allow access for CPR and defibrillation.

*All providers of pre-hospital care should practice and be competent in these skills before they are needed in an emergency situation.



Sports Medicine

Automated External Defibrillator (AED) Protocol

Introduction, Rationale, & Purpose:

Sudden Cardiac Arrest (SCA) will strike greater than 350,000 people per year in the United States, with 95% of those dying. SCA results in the immediate cessation of blood and oxygen flow to the brain. Without proper blood flow, irreparable brain damage will begin in four to six minutes. Rapid intervention, therefore, is required to restore proper heart function and blood flow. The American Heart Association describes the most effective Chain of Survival for treatment of SCA as including:

1. Early Access / Emergency Medical Response
2. Early Cardio-Pulmonary Resuscitation
3. Early Defibrillation
4. Early Application of Advanced Care / ACLS

CPR is most effective when started immediately after the victim's collapse, but the use of basic CPR cannot convert a heart that is in ventricular fibrillation (VF) to a normal rhythm. The purpose of an Automated External Defibrillator (AED) is to rapidly identify and provide early defibrillation to the victim of SCA. Recognition of early warning signs, such as chest pains and discomfort before collapse, and shortness of breath, as well as the availability of an AED and the speed with which defibrillation is performed are major components for a successful resuscitation attempt. The use of AEDs within four to six minutes of the time of SCA has shown to be highly predictive for survival of a victim. AEDs eliminate the need for training in rhythm recognition and make early defibrillation by minimally trained individuals practical and achievable.

Definitions:

- **Ventricular Fibrillation (VF)** - an abnormal heart rhythm that results from very fast, unorganized electrical activity in the heart. An ineffective quivering of the heart ventricles that does not allow for adequate blood flow to the heart, lungs, brain, and the rest of the body characterize VF.

- **Defibrillation** - the delivery of a present amount of electrical energy (“electrical shock”) to the heart intended to stop ventricular defibrillation and allow the heart to regain an organized rhythm. The most effective & definitive treatment for ventricular fibrillation.
- **Automated External Defibrillator (AED)** - a portable device whose purpose is to defibrillate (shock) a heart that is in ventricular fibrillation in order to restore normal heart rhythm.
- **Public Access Defibrillation (PAD)** - the use of automated external defibrillators by individuals other than the traditional providers of emergency healthcare / medicine.

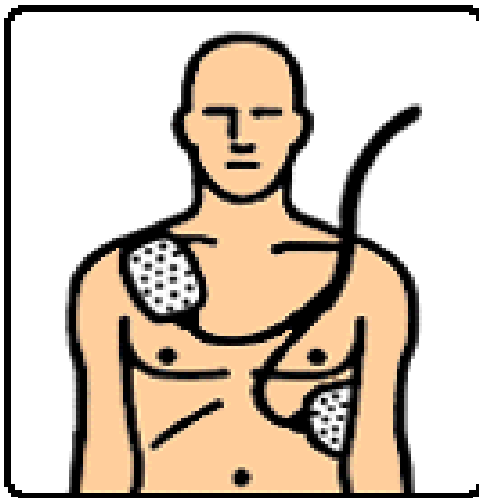
Emergency Procedures:

The following emergency plan is a general outline for all facilities. Specific emergency plans for each facility detailing emergency phone numbers, entrances and access routes, emergency phone locations, etc. are available in each facility.

1. Determine Unresponsiveness- sternal *rub*; “*shake & shout*”.
2. If unresponsive, direct a person to **Call EMS**
 - If alone with an adult victim, call EMS yourself and then tend to the victim.
 - Advise EMS that an AED is on the scene.
3. Direct a person to get the AED (*if alone, get the AED yourself AFTER you have called EMS / UCF Police and then tend to the victim*).
4. Check ABC’s-
 - A** irway- open the airway via the head tilt- chin lift or jaw thrust (suspected cervical spine injury).
 - B** reathing- Look, Listen, & Feel (5 seconds); if not breathing, give two (2) slow breaths; if the breaths do not go in, follow procedures for foreign body airway obstruction (FBAO).
 - C** irculation- check carotid pulse (10 seconds).
5. If the victim does not have a palpable pulse, begin CPR.
6. Once the AED arrives, place the AED next to the victim’s left ear (if possible) and set up according to manufacturer’s directions.



- CPR should be discontinued at the end of the current cycle (after the breaths).
 - Re-assess pulse and breathing.
7. Ensure a safe and ideal environment for AED operation.
- Remove all jewelry and metal from the victim.
 - Remove clothing and undergarments from the victim's chest.
 - Dry / wipe off any water and/or excessive moisture from the patient's chest that could prevent the pads from sticking properly to the victim's chest (if necessary).
 - Shave the victim's chest (if necessary).
 - ***All cellular phones, radios, etc. must be kept a minimum of six (6) feet (two meters) away from the AED when it is in use.***
8. Open the device and power-on the unit by lifting the lid (latch in front of unit, adjacent to the handle) and follow the AED's voice and/or text prompts.
- Take the defibrillation electrodes out of the unit (electrodes are already connected to the unit).
9. **APPLY** the adhesive electrode pads to the patient's bare, dry, exposed chest.
- Stop CPR to ensure proper pad placement.
 - Peel away the protective plastic backing from the electrode pads to expose the adhesive surface.
 - ***It is important to place the pads correctly and press them firmly-including around the edges.***
 - Right pad- right of the sternum (breastbone), in between the clavicle (collarbone) and the nipple.
 - Left pad- outside of the victim's left nipple, 2-3" below the axilla (armpit).



10. Allow the AED unit to **ANALYZE** the heart rhythm-
- **Should be less than 90 seconds from the time the AED is received to when it is attached to the victim and analyzing the victim's heart rhythm.**
 - Stop CPR.
 - The machine will say *“do not touch the patient; analyzing rhythm”*.
 - Do not touch the victim or have any contact with the victim while the AED is analyzing!
 - Rhythm analysis can take up to 15 seconds.
11. **SHOCK** (if indicated)-
- If a shock is indicated, the machine will say *“shock indicated, charging, stand clear, push flashing button to deliver shock”*, as well as give screen prompts. The orange shock button at the bottom left corner of the AED unit will also flash.
 - The rescuer should announce, ***“I’M CLEAR, YOU’RE CLEAR, ALL CLEAR”***, and perform a visual inspection of the immediate area surrounding the patient (e.g. patient contact, water, etc.) before shocking. This should ensure that no one, including the rescuer, is in contact with the patient.
 - If anyone is touching the victim and/or there is not a safe and ideal environment, the rescuer **SHOULD NOT** push the SHOCK button until contact with the victim stops and/or a safe and ideal environment for AED operation exists.
 - After loudly saying *“Clear”* and doing a *visual check of the victim’s entire body*, the rescuer should push the ***flashing orange shock button*** at the bottom left corner of the AED unit to shock the patient.
 - The shock will not be delivered unless the rescuer presses the button!
 - The AED unit is pre-programmed with default settings that support popular protocols for the number of shocks delivered in a series, the energy level for each shock, and the use of CPR.
12. The AED unit will then analyze the heart rhythm following the shock and make recommendations for further action- further shocks are needed (follow above sequence) or *“no shock indicated”* (check pulse & breathing).
13. The AED will deliver up to three (3) shocks in a series. If there is no pulse after the third shock, return to CPR (leave the electrodes attached) for one (1) minute and then analyze rhythm again after one (1) minute of CPR.
- The AED machine will have a timer mechanism that will automatically begin re-analyzing after one (1) minute.
14. Do NOT remove the electrode pads or turn the AED off until instructed to do so by EMS personnel.

“If’s”:

- If “***no shock indicated***”- check pulse & breathing; begin CPR, rescue breathing, or monitoring (whichever is indicated by the pulse & breathing assessment).
 - The AED unit will continue to monitor the patient’s heart rhythm and, if it detects a potentially shock able rhythm, it will prompt the rescuer to immediately stop CPR and/or avoid touch the patient so it can perform a rhythm analysis.
- If the victim is ***breathing adequately and has a pulse***- place victim in the recovery position & monitor ABC’s.
- If the victim is ***not breathing, but has a pulse***- perform rescue breathing (1 breath every 5 seconds) & reassess pulse frequently.
- If victim is ***not breathing & does not have a pulse***- resume CPR.

Special Situations:

Water-

- Victim lying in water / rescuer kneeling in water (e.g. pool deck, locker room).
- May cause burns or shocks to the victim or rescuer(s).
- Carefully remove the victim from contact with water.
- Dry the victim’s chest quickly before attaching the AED.

Metal-

- Victim or rescuer on a metal surface.
- Metal on the victim (e.g. nipple rings, bra, etc.).
- All metal conducts electric current.
- Chance of the electric charge shocking a rescuer or bystander.
- Remove ALL metal located above the victim’s waist.



Sports Medicine Concussion Protocol

- Background:** A concussion is a Traumatic Brain Injury (TBI) that interferes with normal brain function. Loss of consciousness DOES NOT have to occur for a concussion to occur. Concussions usually occur by the sudden deceleration or complete stoppage of a moving skull. As the skull moves, the brain moves with it. When the skull decelerates or suddenly stops, the brain continues to move until it rams into the skull, which stops it, causing a TBI.
- Symptoms:** Include but not limited to headache, nausea, vomiting, slurred speech, dizziness, difficulty concentrating, slowed thought process, lethargy, ringing of the ears, poor balance, sensitivity to light, inappropriate mood, may or may not involve loss of consciousness. Athletes and parents will be provided with educational materials and be asked to sign a form acknowledging understanding.
- Evaluation:** Athletes will complete a pre-season Impact (cognitive and neurologic) Test to establish a baseline value. If present, the Certified Athletic Trainer (ATC) will assess the athlete suspected of having a concussion and make the diagnosis of whether the athlete has sustained a concussion or not. If the ATC is not present, the head coach assumes responsibility for the athlete. If the ATC makes the diagnosis of concussion, he will notify the athlete's parent/guardian and educate them on the protocol. **ONLY** one of the following health care professionals can make the diagnosis of a concussion: MD (medical doctor), DO (doctor of osteopathic medicine), PA (physician's assistant), NP (nurse practitioner), PM (paramedic) or AT (athletic trainer).
- Return to Play:** No athlete shall return to play on the same day that he sustains a concussion. **ONLY A MD OR DO CAN RELEASE AN ATHLETE DIAGNOSED AS HAVING A CONCUSSION TO RETURN TO PLAY!** Athletes will be sent home with a home instruction sheet and must have LHSAA Release Form in addition to doctor's release prior to return.

St. Paul's Sports Medicine Concussion Evaluation

Name: _____ Date of Injury: _____ Time of Injury: _____

Subjective/Symptoms:

<u>Graded Symptom Checklist (GSC)</u>					
Symptom	Time of injury	2-3 Hours postinjury	24 Hours postinjury	48 Hours postinjury	72 Hours postinjury
Blurred vision					
Dizziness					
Drowsiness					
Excess sleep					
Easily distracted					
Fatigue					
Feel "in a fog"					
Feel "slowed down"					
Headache					
Inappropriate emotions					
Irritability					
Loss of consciousness					
Loss or orientation					
Memory problems					
Nausea					
Nervousness					
Personality change					
Poor balance/ coordination					
Poor concentration					
Ringling in ears					
Sadness					
Seeing stars					
Sensitivity to light					
Sensitivity to noise					
Sleep disturbance					
Vacant stare/glassy eyed					
Vomiting					

NOTE: The GSC should be used not only for the initial evaluation but for each subsequent follow-up assessment until all signs and symptoms have cleared at rest and during physical exertion. In lieu of simply checking each symptom present, the ATC can ask the athlete to grade or score the severity of the symptom on a scale of 0-6, where 0=not present, 1=mild, 3=moderate, and 6=most severe.

Objective/Memory : (Check if Answered Correctly)

_____ “At what venue are we today?”

_____ “Which half is it now?”

_____ “Who scored last in this game?”

_____ “What team did you play last week/game?”

_____ “Did your team win the last game?”

****Failure to answer all questions correctly may suggest a concussion.***

Objective/Balance: (Number of Errors in 20 Seconds; Max of 10 Each Stance)

_____ Double Leg Stance (Feet Together)

_____ Single Leg Stance (Non-Dominant Foot)

_____ Tandem Stance (Non-Dominant Foot Back)

_____ Total Errors

Assessment:

Plan:

_____ LHSAA “Home Instruction Sheet” Sent Home

_____ LHSAA “Return to Competition” Sheet Sent Home

ATC Signature: _____

ATC Cell Phone: _____

**Louisiana High School Athletic Association
Concussion Information: Home Instruction Sheet**

Name: _____

Date: _____

You have had a head injury or concussion and need to be watched closely for the next 24-48 hours.

It is OK to:	There is no need to:	DO NOT:
Use Tylenol (acetaminophen)	Check eyes with a light	Drink Alcohol
Use an ice pack to head/neck for comfort	Wake up every hour	Eat spicy foods
Eat a light meal	Stay in bed	Drive a car
Go to sleep		Use aspirin, Aleve, Advil or other NSAID products

Special Recommendations: _____

WATCH FOR ANY OF THE FOLLOWING PROBLEMS:	
Worsening headache	Stumbling/loss of balance
Vomiting	Weakness in one arm/leg
Decreased level of Consciousness	Blurred Vision
Dilated Pupils	Increase irritability
Increased Confusion	

If any of these problems develop, call your athletic trainer or physician immediately.

Athletic Trainer: _____

Phone: _____

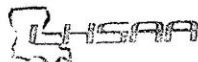
Physician: _____

Phone: _____

You need to be seen for a follow-up examination at _____ AM/PM at: _____

Recommendations provided to _____

Recommendation provided by _____



LHSAA BASIC CONCUSSION RULE

Any player who exhibits signs, symptoms or behaviors consistent with a concussion (such as loss of consciousness, headache, dizziness, confusion or balance problems) shall be immediately removed from the contest and shall not return to play until cleared by an appropriate health-care professional.

A concussion is a traumatic brain injury that interferes with normal brain function. An athlete does not have to lose consciousness to have suffered a concussion.

**Common Symptoms of Concussion include:
headache, fogginess, difficulty concentrating, easily confused, slowed thought processes, difficulty with memory, nausea, lack of energy, dizziness or poor balance, blurred vision, sensitive to light and sounds, mood changes □
irritable, anxious, or tearful**

LHSAA Adopted Concussion Management Protocol:

- 1. No athlete shall return to play (RTP) or practice on the same day of a concussion.**
- 2. Any athlete suspected of having a concussion shall be evaluated by an appropriate health-care professional (certified athletic trainer/ATC) that day. If one is not available, the head coach shall make the determination.**
- 3. Any athlete diagnosed with a concussion shall be medically cleared by a Medical Doctor (MD) or a Doctor of Osteopathic Medicine (DO), each of which must be licensed to practice in Louisiana, prior to resuming participation in any practice or competition.**
- 4. After medical clearance, RTP should follow a step-wise protocol with provisions as determined by a Medical Doctor or Doctor of Osteopathic Medicine, each licensed to practice in Louisiana, for delayed RTP based upon return of any signs or symptoms.**

Name: _____

Date of Concussion (head trauma): _____

Loss of Consciousness: Yes No

Date of Private Physician Clearance: _____

Stage	Asymptomatic (no signs or symptoms of a concussion) Date & Initials of Examiner
Stage 1A: Rest (physical & mental)	Pass (P) Fail (F): Reason for failure: Initials: _____
Stage 1B: Return to class/academics	P F Date _____ P F Date _____ P F _____ Reason for failure: Initials: 1. _____ 2. _____ 3. _____
Stage 2: Light aerobic activity (e.g. walking, jogging, stationary bike)	P F Date _____ P F Date _____ P F _____ Reason for failure: Initials: 1. _____ 2. _____ 3. _____
Stage 3: Sport-specific training	P F Date _____ P F Date _____ P F _____ Reason for failure: Initials: 1. _____ 2. _____ 3. _____
Stage 4: Non-contact training drills (start light-resistance training)	P F Date _____ P F Date _____ P F _____ Reason for failure: Initials: 1. _____ 2. _____ 3. _____
Stage 5: Full-contact training after medical clearance by the school physician	P F Date _____ P F Date _____ P F _____ Reason for failure: Initials: 1. _____ 2. _____ 3. _____
Stage 6: Return to competition (game play)	District Physician signature & date

Signs & symptoms of a post-concussion syndrome

1. Seizure/convulsion
2. amnesia
3. headache
4. "pressure in head"
5. neck pain
6. nausea
7. dizziness
8. blurred vision
9. balance problems
10. sensitivity to light or noise
11. feeling slowed down
12. feeling like "in a fog"
13. "don't feel right"
14. difficulty concentrating or remembering
15. fatigue or low energy
16. confusion, drowsiness
17. more emotional irritability
18. sadness
19. nervous or anxious

LHSAA Return to Competition Form

LHSAA rules require a written statement from a physician in order for an athlete to return to competition who apparently had a concussion.

"If a competitor is determined to have a concussion, he/she shall not be permitted to continue practice or competition the same day. Written approval of a physician shall be required for the athlete to return to competition. If a physician recommends an athlete not continue, he/she shall not be overruled".

The undersigned attending physician has examined the student athlete identified below and gives permission for the student athlete to return to competition on the date and in the event identified.

ATHLETE:	_____
SCHOOL:	_____
SPORT:	_____ DATE of CONCUSSION _____
ACTIVITY:	_____ DATE to RETURN _____

Attending Physician Name (Print)

La. Medical License

Attending Physician Signature

Date Signed

(Duplicate as needed)

This form shall be completed in its entirety and one copy sent to the LHSAA and one copy kept on file at the school.

Notification of Injury Form

Student Name (Last, First):

Description of Injury:

Injury Date:

Place:

Activity:

Grade:

Traveling to/from school or school-sponsored activity?

During school hours?

During a school activity?

Signature of Authorized School Representative?

Title:

Date:



Sports Medicine

Football Camp Emergency Action Plan

Emergency Phone Numbers:

Chris Stipe, Head Athletic Trainer: 985-789-4105

Kenny Sears, Head Football Coach: 985-966-1143

Thibodaux Regional Medical Center: 985-447-5500

- Venue:** Nicholls State University
906 E. 1st St.
Thibodaux, LA 70310
(985) 446-8111
- Personnel:** Certified Athletic Trainer, Chris Stipe, on site; Head Football Coach, Kenny Sears, on site; Emergency Medical Services, EMS via 911 if necessary; nearest emergency room, Thibodaux Regional Medical Center, if necessary.
- Equipment:** Heat illness supplies (ice, ice immersion bath, fans, tables, tents, stretchers, cervical collars) centrally located on site at athletic trainer's station daily; athletic trainer's kit (any other medical supplies) centrally located on site at athletic trainer's station or in golf cart with athletic trainer daily.
- Responders' Roles:**
1. Immediate care of the injured or ill student athlete. (Keep the athlete calm and/or motionless until the athletic trainer arrives on site.)
 2. Call/send for the athletic trainer immediately or, if necessary, activate EMS by calling 911. (Provide name, address, telephone number, number of individuals injured and condition of the injured, first aid being administered, specific directions and any other needed information.)

3. Direction of EMS to scene, open appropriate gates, designate individual to flag down EMS and direct them to the scene, scene control (limit scene to first aid responders and athletic trainer only, all others should move away from area.)
4. All injuries/illness **MUST** be referred to athletic trainer.

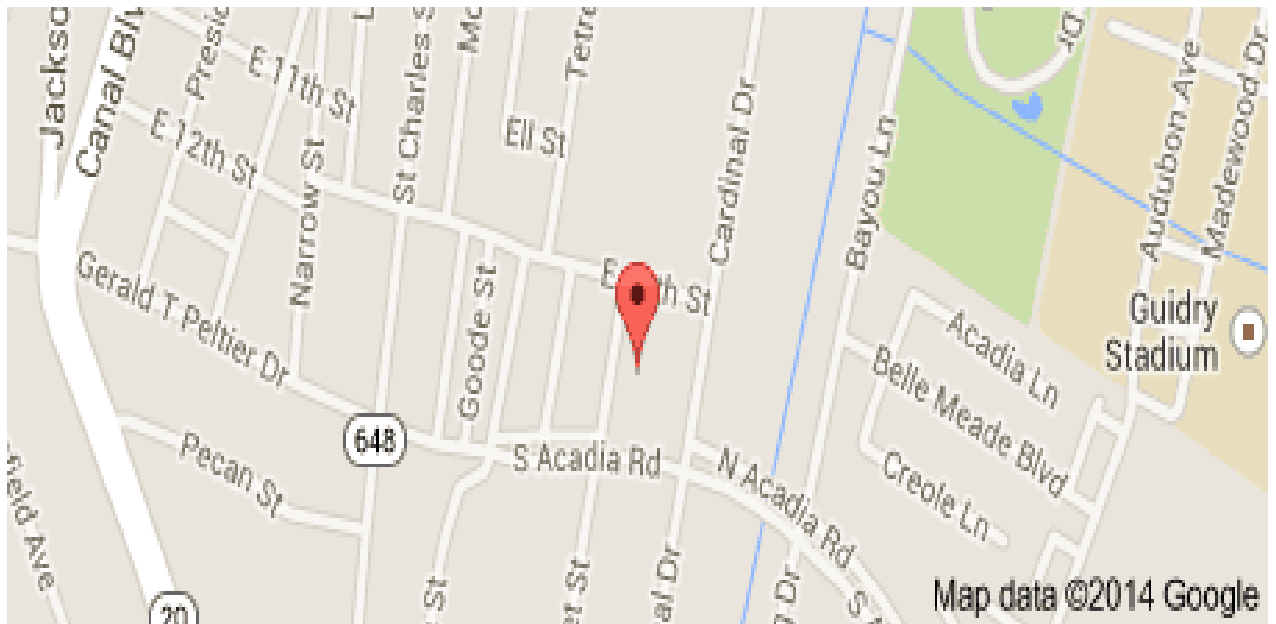
Directions:

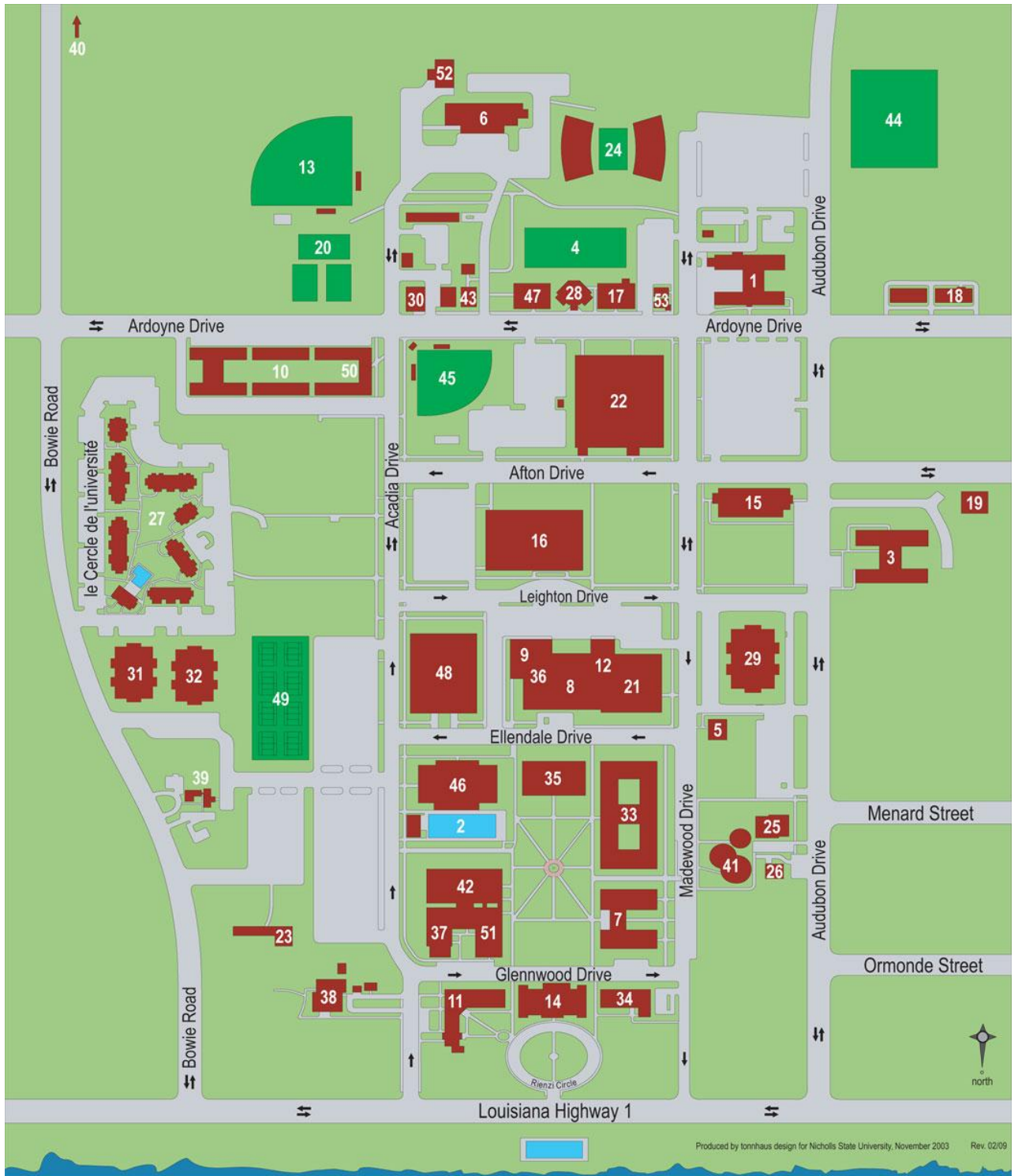
1. Take Causeway Toll Bridge South towards Metairie.
2. Merge onto I-10 W toward Baton Rouge.
3. Merge onto I-310 S via Exit 220 toward Boutte/Houma.
4. Merge onto US-90 W toward Houma.
5. Take the LA-1 exit toward Lockport/Thibodaux.
6. Turn left onto Hwy One/LA-1 N.
7. End at 906 E 1st St – Thibodaux, LA 70310

Hospital Address:

Thibodaux Regional Medical Center
602 North Acadia Road Thibodaux, LA 70301
Thibodaux, LA 70302
SEE LOCATION BELOW

Maps:





Produced by Ionnhaus design for Nicholls State University, November 2003 Rev. 02/09

- | | | | | |
|----------------------------|----------------------------------|---------------------------------------|--|-----------------------------------|
| 1. Ayo Hall | 13. Didier Field (Baseball) | 25. Historical Research Center D.H.T. | 37. Powell Hall | 49. Tennis Courts |
| 2. Ayo Swimming Pool | 14. Elkins Hall | 26. James Alumni House | 38. President's Residence | 50. University Police |
| 3. Babington Hall | 15. Ellender Hall | 27. La Maison du Bayou | 39. Pupil Appraisal Center L.P.S.B. | (Information Center) |
| 4. Band Practice Field | 16. Ellender Memorial Library | 28. Lindsley Hall (Music Annex) | 40. Safety and Environmental Building | 51. White Hall |
| 5. Baptist Student Center | 17. Family and Consumer Sciences | 29. Scholars Hall | 41. St. Thomas Aquinas Center (Chapel) | 52. Chabert Hall |
| 6. Barker Hall and Annex | 18. Family Housing | 30. Maintenance Buildings | 42. Shaver Gymnasium | 53. Continuing Education Building |
| 7. Beauregard Hall | 19. Family Service Center | 31. Residence Hall B | 43. SLEC / Region III Service Center | |
| 8. Bollinger Student Union | 20. Football Practice Field | 32. Residence Hall C | 44. Soccer Field | |
| 9. Bookstore | 21. Galliano Hall (Cafeteria) | 33. Peltier Hall | 45. Softball Field | |
| 10. Calecas Hall | 22. Gouaux Hall | 34. Picciola Hall | 46. Stopher Gymnasium | |
| 11. Candies Hall | 23. Greenhouse | 35. Polk Hall | 47. Student Publications & Printing | |
| 12. Cotillion Ballroom | 24. Guidry Stadium | 36. Post Office | 48. Talbot Hall | |

NICHOLLS
STATE UNIVERSITY



Sports Medicine

Blood Borne Pathogen Protocol

As an athlete or school official, you may be at risk and exposure to blood-borne pathogens, including hepatitis B (HBV), hepatitis C (HCV), and human immunodeficiency virus (HIV).

An exposure incident is defined as follows:

- Skin pierced, cut, or scratched by a sharp object contaminated with blood or other potentially infectious body fluid
- Spills or splashes of blood or other potentially infectious material onto non-intact skin (cuts, hangnails, abrasions, chapped skin) or any mucous membrane

Most exposures do not result in an infection and the risk of infection may vary with such factors as:

- Pathogen involved
- Type of exposure
- Amount of blood involved in the exposure
- Amount of virus in the patient's blood at the time of exposure

If an exposure occurs:

- When an exposure occurs, stop immediately with the procedure you are involved with and:
- Wash needle sticks and cuts with soap and water
- Flush splashes to the nose, mouth, or skin with water
- If eyes are exposed to blood or contaminated body fluids, flush with water or saline for 15 minutes and notify the supervising athletic trainer

Universal precautions

- Universal precautions are an approach to infection control. According to the concept of Universal precautions, all human blood and certain human body fluids are treated as if known to be infection for HIV, HBV, and other blood-borne pathogens. To prevent an exposure to infection, adhere to the following guidelines.
- Avoid contact with blood and other bodily fluids
- Use breathing barriers such as resuscitation masks when giving rescue breaths to a victim
- Wear disposable gloves when providing care, particularly if you may come into contact with blood or bodily fluids
- Use gloves that are appropriate to the task and provide an adequate barrier
- Remove jewelry, including rings, before wearing disposable gloves
- Keep any cuts, scrapes or sores covered before putting on protective clothing
- Do not use disposable gloves that are discolored, torn or punctured
- Do not clean or reuse disposable gloves
- Avoid handling items such as pens, combs, or radios when wearing soiled gloves
- Change gloves before giving care to a different victim
- Do not wear gloves and other personal protective equipment away from the workplace
- Remove disposable gloves without contacting the soiled part of the gloves and dispose of them in a proper container
- Wash hands thoroughly after contact with each athlete