

**NOVANT HEALTH SECONDARY SCHOOLS
GENERAL POLICIES AND PROCEDURES FOR
ATHLETIC TRAINING PROGRAM OPERATION AND MANAGEMENT**

8/14/18 at 1:00 PM

PURPOSE

The athletic training staff is primarily responsible for the delivery of the health care system to all athletes participating in jayvee and varsity athletics at Bishop McGuinness Catholic High School. This health care includes prevention, counseling, evaluation/diagnosis, and assessments of health status, provide first aid and emergency care, provide and/or develop treatment and rehabilitation plans, make medical referrals for diagnosis and health care strategy instructions, and manage injuries or illnesses sustained during practices or games, as well as on site coverage of practices and games. The focus of the athletic training health care interventions is targeted at returning student-athletes to pre-injury performance levels as quickly and as safely as possible with maximum attention to prevention of recurrence resulting from incomplete rehabilitation. In addition, the athletic training staff will provide the necessary services to function as part of the secondary school community. Collaboration and maintaining a strong working relationship with student health services and the **504** coordinator is essential.

All members of the Bishop McGuinness Catholic High School Athletic Training Staff are BOC credentialed and in good standing and possess NCBATE licensure. The athletic training staff provides care under the direction of the team physicians and/or their designees. Standing orders/licensure protocol is approved and sign-off on by the team physician. A copy of the Novant Health NCBATE protocol is attached here as Appendix # __1__. Collaboration and coordination are an essential part of sports health care and is encouraged by the Bishop McGuinness Catholic High School athletic training staff and the medical professionals providing services to student athletes.

MISSION STATEMENT

As Athletic Trainers Certified (ATC), we understand that possibility and accept the challenge to strive to prevent, minimize, treat, and rehabilitate/recondition such injuries. Working cooperatively with the athlete, parent, and coach – under the direction of the team physician – the athletic trainer will attempt to provide quality sports health care for each athlete.

BISHOP MCGUINNESS CATHOLIC HIGH SCHOOL SPORTS MEDICINE TEAM MEMBERS

Orthopedic Team Physician(s)	Chris Brumfield, MD Jennifer Harvey, MD
Novant Health Athletic Trainer	Brittany Price MS, LAT, ATC
First Responder(s)	Brian Smith

Physician's addresses and office phones:

Orthopedic Physician: Chris Brumfield (Cell) 336-688-0806 (O) (336) 277-4460

NH Orthopedics Kernersville 280 Broad St Suite B, Kernersville, NC 27284

Physical Therapy Referral Resource 336-996-7001

NH Kernersville Physical Therapy 109 Gateway Center Drive Kernersville, NC 27284

**Local Novant Hospital & Urgent Care Center: Kernersville Medical Center
1750 Kernersville Medical Pkwy, Kernersville, NC 27284 (336) 564-4000**

First Responder:

Brian Smith

AD: Jeff Stoller 336-707-3252 jstoller@bmhs.us

Primary Care Office Mgr.: Linda Wooten 336-718-7808

Ortho Office Mr. Ryan Billings (o) 336-277-4460 / cell 302-632-3396

Local Hospital and Urgent Care:

1750 Kernersville Medical Pkwy

Kernersville, NC 27284

336-564-4000

Cone Health Urgent Care at MedCenter Kernersville

1635 NC Hwy 66S #125

Kernersville, NC 27284

336-992-4800

Athletic Trainer Job Description

The ATC reports to the Novant Health Supervisor of Athletic Trainers and to the Athletic Director (AD). The ATC attends scheduled practices and interscholastic athletic contests as assigned by the AD. The responsibilities of the ATC shall include, but may not be limited to the following:

- 1) Posses Board of Certification (BOC) certification and fulfill the requirements to hold a current NC state license to practice as an athletic trainer.
- 2) Provide on-site injury care and evaluation as well as appropriate acute care treatments & first aid, follow-up treatment and rehabilitation as necessary for all injuries sustained by student athletes. This will include travel to home and away football contests.
- 3) Coordinate with team physician to provide:
 - a) Coverage for Home Varsity Football games
 - b) On site visits to evaluate and treat athletes from all sports when needed
 - c) Follow-up injury care in physician's office as needed
 - d) Reconditioning programs
 - e) Assistance on all matters pertaining to the health and well-being of student athletes
- 4) Coordinate with the athletic director the EMS services to provide:
 - a) Coverage for Home Varsity Football games
 - b) Defined rolls when Emergency Medical Services (EMS) is called
- 5) Determine when an athlete may safely return to full participation after an injury (following a physician's authorization when needed)
- 6) Maintain complete and accurate records of all athletic injuries and treatments rendered
- 7) Notify parents or legal guardians and recommend appropriate medical care when the athletic trainers deem a significant injury has occurred
- 8) Supervise the selection, fitting, and maintenance of protective equipment
- 9) Aid the coaching staff in the development and implementation of conditioning programs
- 10) Supervise the Athletic Training Room (ATR) and inspect the playing facilities along with the coaching staff
- 11) Select and maintain athletic training equipment and supplies
- 12) Assist in maintenance of medical records to include but not limited to pre-participation examinations, medical history, emergency contact information, and parent/guardian insurance coverage and treatment/rehabilitation notes.
- 13) Obtain current student athlete emergency contact information from athletic director's office or as provided from required pre-participation medical examination forms.
- 14) Provide base-line concussion testing and compliance with the NC Gfeller-Waller Concussion Act.

ATHLETIC TRAINING ROOM GENERAL OPERATIONAL HOURS

The Athletic Training Center will be open:

Monday - Friday 12:30pm-Until

Saturday/Holidays Closed

It is often necessary for the Athletic Training Room to remain open past the scheduled times. These times are for specific team practices or event coverage. The Athletic Training Room shall remain operational during all practices and events. When the athletic training facility is not in use it will always remain locked. These facilities are under the direct supervision of the Head Athletic Trainer and certified staff athletic trainers. No athlete or patient will be allowed in the Athletic Training Center without supervision. Only the certified athletic training staff who are trained in therapeutic modalities may apply them. Due to their potential danger, no student first aiders may apply therapeutic modalities. Athletic training student aides may apply ice packs or hot packs under the supervision of a staff certified athletic trainer.

ATHLETIC TRAINING ROOM POLICIES FOR ATHLETES

1. Report all injuries and illnesses as soon as possible.
2. Report for all treatments and doctors' appointments on time.
3. Do not remove any equipment from the Athletic Training Center without authorization.
4. Do not dress or undress in the Athletic Training Center. Leave all equipment and book bags in your locker-room!
5. Wear proper attire for any treatment being given. (Shirts with sleeves-shoes-shorts and underwear must be worn in the Athletic Training Room)
6. After practice, you **MUST** shower before routine treatment of injuries and wounds.
7. Please help to keep the Athletic Training Center clean.
8. Avoid horseplay, improper language, or any behavior unbecoming of a BMHS athlete.
9. Respect the requests of the athletic training staff just as you would your coaching staff. Failure to comply with athletic training room policy or with athletic training staff will result in loss of athletic training room privileges.
10. Stay out of the Athletic Training Center unless you are there for a purpose. The athletic training room is not a place for socialization.
11. No beverages, eating, "chewing," or "dipping" etc. in the Athletic Training Center.
12. No cleats or spikes allowed in the Athletic Training Center. Keep all shoes off the treatment tables.
13. The Athletic Training Center will not be an excuse for being late to practice or class.
14. No taking of photos or use of cell phone without permission of a staff athletic trainer.

PROFESSIONALISM

Due to the clinical nature of the staff athletic trainer position and athletic training student aides, it is expected that all staff and athletic training student aides will conduct themselves in a professional and ethical manner while on duty and representing the Athletic Training Department and Bishop McGuinness Catholic High School. Unprofessional and unethical behavior will not be tolerated and will be dealt with by the administrative staff. Unprofessional and unethical behavior may be cause for corrective action and/or dismissal. All codes of ethical conduct are to be observed, including the NATA Code of Ethics. The NATA Code of Ethics can be found at www.nata.org. Additionally, the certified athletic trainers maintain required CEUs per BOC guidelines and place importance on staying up to date on relative sports medicine issues and best-practices. All certified athletic trainers must be NCBATE licensed, abide by team physician protocols, obey licensure laws as are related to the practice of athletic training, as well as adhere to the BOC Standards of Professional Practice.

PROFESSIONAL DRESS

Professional dress is required all times when athletic training personnel are on duty. Novant employees will be required to wear their provided Novant apparel. Approved Bishop McGuinness Catholic High School Athletic Training polo shirt and shorts or pants shall be worn on limited occasions while covering or performing clinical care events in the athletic training room or outside on the playing fields. Pants and shorts can be khaki, tan, white, navy, gray, black or brown. Shorts to be worn outdoors must have pockets. During inclement weather, pull-overs, sweatshirts, jackets, warm-up pants and other appropriate apparel is permitted. Hats are allowed to be worn outdoors if it is a Novant hat. At game day events, the game day Novant apparel is required for Novant employees. Closed-toed and closed-heeled shoes with socks must be always worn while on-duty in accordance with OSHA standards (NO bare feet). On days of inclement weather, the use of umbrellas or rain boots is permitted. Dress for team travel and related events such as team meals, team movies, etc. will be at the discretion of the supervisor in charge of the event. Note that shirts must be always tucked in, and a belt must be with pants and shorts. Jewelry must be conservative in style, size, and color. Jewelry must not be dangling or distracting and not hinder the daily work-related activities and tasks. Clothing should cover all visible tattoos.

The following types of clothes will NOT be permitted while on duty: sandals, tank tops, running shorts, "work out" clothing, open-toed or open-heeled shoes and other clothing deemed inappropriate by the NH Supervisor of Athletic Trainers. *If you are NOT sure if an item is appropriate, please do not wear it. Such articles can be brought in for prior approval from the NH Supervisor of Athletic Trainers.

Make-up and perfume or cologne must be conservative in use and presentation. Nails must be clean and neatly trimmed with conservative polish colors if applied. No artificial nails or nails of excessive length are permitted and those deemed inappropriate by your supervisor will not be tolerated.

The way you look and dress is not only a reflection of you, but the entire Novant Health Athletic Training Program and your assigned outreach site. You should not wear anything that makes you "stand out" or draws attention to yourself. Untidiness, poor personal hygiene, or sloppiness will not be tolerated when you are on duty. .

PROCEDURES FOR THE CARE OF ATHLETIC INJURIES

The fact that injuries are an inherent part of athletic participation deems it the responsibility of any administration to provide for the health care of those athletes that participate in inter-scholastic athletics. In accordance with this philosophy, Novant Health provides adequate medical care for those student athletes through the Athletic Training outreach program. Each staff athletic trainer has a copy of the physician signed protocols for directing and providing care for athletic injuries and conditions. This protocol list includes Training Room Policies & Procedures, Medications, Concussion, Heat Illness, Cold Exposure, Lightning & Tornado, Cardiac & AED, Orthopedic, Blood Borne Pathogen, EpiPen, Asthma, Mononucleosis, Electrical Safety, Spinal Injury Management, Eating Disorders, Air Quality, Adverse Medical Event, Sick Cell, Skin Infections and Catastrophic Event. The protocols are also on-file in the Athletic Trainer's Office. The protocols and policies are attached at the end of this document.

PREVENTION OF INJURIES

The primary concern of the entire athletic training program is to prevent any athletic injuries to its athletes. Many of the policies and procedures are designed to meet this goal. New strategies are developed as needed. Education and communication are provided to those athletes, coaches and administrators as needed or deemed necessary.

PRE-PARTICIPATION EXAMINATIONS (Appendix 3)

All athletes must receive a medical examination prior to participation in their respective sport. New athletes will complete the pre-participation packet including medical history and policies and procedures prior to undergoing a comprehensive physical. Returning athletes will complete a yearly physical examination and the medical history questionnaire and other forms as required by the NCHSAA and their respective school. If any new injuries/illnesses have occurred since the end of the previous competitive season, the athlete may be referred to the team physician. All

medical records will be kept in the Athletic Training Room in a locked filing cabinet. All required medical forms for participation and insurance information can be found on the Bishop McGuinness High School website:

www.bmhs.us

EVALUATION OF ATHLETIC INJURIES

The team physician and the certified staff athletic trainers are the individuals responsible for diagnosis of all athletic injuries and illnesses. It is the responsibility of any athlete requiring medical assistance because of an athletic injury to report this injury to the athletic training staff as soon as possible. For every injury reported to the athletic training staff, an evaluation should be done, and a complete injury report is to be filled out and documented. The athletic training staff shall be responsible for maintaining complete documentation of student-athlete health care screening, history, and the treatment of injuries, including symptoms, responses, progress and physician diagnosis and consultation. Athletic Training Personnel shall respect the student-athletes right to privacy by protecting confidential information unless obligated or allowed by law to disclose such information. No coach should ever overstep his/her legal bounds by diagnosing and/or performing or recommending treatment for an injury over a period. This leaves both the individual and Bishop McGuinness Catholic High School vulnerable to legal action.

If necessary, any medical diagnosis and prescribed treatment will be coordinated by the athletic training staff through the team physician or to the appropriate allied health care specialist. Failure to do so may result in unnecessary lengthy rehabilitation and prolonged absence from sport participation. Any athlete dissatisfied with his/her injury diagnosis or recovery progress should notify the athletic training staff and team physician and request additional consultation. The team physician should make every effort to provide the best possible health care to the athlete.

Any injury occurring after Athletic Training hours, when an athletic trainer is not present, shall be assessed as life threatening or non-life-threatening. In the case of a life-threatening injury, the coach should call 911 to activate the Emergency Medical System and then notify a member of the certified staff as soon as possible. In the case of a non-life-threatening injury, the coach should contact one of the certified staff as soon as possible to receive instructions on appropriate health care. The NH Athletic Trainers can assist as needed in making medical appointments and referrals to the team physicians for care. All athletes injured on an away trip should return to Bishop McGuinness Catholic High School if possible and report any medical concerns to the athletic trainer. When the team physician or athletic training staff do not accompany the team on a trip, the coach is responsible for obtaining the help necessary from the host school's certified athletic trainer, team physician or identified provider. A copy of the Emergency Action Plans for Bishop McGuinness Catholic High School is attached as appendices. For further information on the Evaluation of Athletic Injuries procedures see **Practice and Game Procedures for an Injured or Ill Student Athlete & General Return to Play Protocol (Appendix #__2__)**

If an athlete reports to the athletic training staff a medical illness or non-orthopedic condition, the athlete will be assessed. If necessary, the athlete maybe withheld from athletic activity until such time he/she is evaluated and released to full activity by a licensed health care provider. Additionally, the student-athlete's parent or guardian will be notified of the illness/condition with the recommendation that their son/daughter should seek medical referral for the present illness/condition.

TREATMENT OF ATHLETIC INJURIES

It is the athlete's responsibility to follow recommended Athletic Training Department procedures for the care and handling of any athletic injury. Failure to do so may result in unnecessary lengthy rehabilitation and prolonged absence from participation in that sport. The athletic training staff will administer immediate first aid to all injured athletes. Injuries seen by the athletic training staff will be classified into three categories and treated accordingly:

- A. Minor injury
- B. Non-life-threatening serious injury
- C. Life threatening serious injury

The Blood Borne Pathogens & Exposure Control Policy for the Athletic Training Program will be utilized and adhered to for treating injuries and this document is attached along with applicable physician protocols and standing orders. As noted earlier, injured student athletes are to receive treatment and rehabilitation during times that athletic training room is open/available. All certified athletic trainers will be directly involved with coordinating the necessary care for those student-athletes that need treatment and rehabilitation.

If necessary, any medical diagnosis and prescribed treatment will be made through the team physician. All athletic training services provided to student-athletes must be directly supervised and coordinated by the staff athletic trainers for Bishop McGuinness Catholic High School without exception. The EAP will be utilized as deemed necessary for life-threatening injuries.

The Emergency Action Plans for Bishop McGuinness Catholic High School are attached here as appendices. (Appendix 4)

TEAM COVERAGE

Direct coverage of Bishop McGuinness Catholic High School athletic teams will be assigned by the NH Athletic Trainer and coordinated with the athletic director. Home event coverage shall take priority over teams traveling off-campus. Those sporting events of high risk will take priority over those of low risk per direct coverage. In-season sports shall have priority over non-traditional seasons regarding direct practice or game coverage. Coverage of games and practices is often dependent upon staff availability and can be changed as needed at the discretion of the NH Athletic Trainer.

VISITING INJURED ATHLETES

Any visiting athlete injured on the campus of Bishop McGuinness Catholic High School shall receive the same quality initial care as BMHS athletes. If the visiting team has a team physician and/or certified athletic trainer, they will be given assistance in any manner possible. A certified athletic trainer will be available for all home contests to assist the visiting team athletes if necessary. Information regarding services provided to visiting teams can be found at/listed here: (Appendix 4)

The use of electro-modalities in the treatment of visiting athletes will be subject to the following guidelines:

1. The visiting certified athletic trainer must perform electro-modalities.
2. If no athletic trainer accompanies the visiting team, electro-modalities will only be provided if the visiting team's certified athletic trainer or physician provides written instructions.
3. Athletes of visiting teams who require medical equipment to facilitate their trip home, e.g., crutches, will be provided the equipment necessary. It is expected that this equipment will be returned at the expense of the visiting team.
4. In the event an injured visiting athlete requires follow-up medical care and is not accompanied by an athletic trainer, the certified staff member covering that event shall contact the athlete's athletic trainer and/or team physician at the earliest opportunity. Direct communication with the head coach and/or parents may be an acceptable alternative to provide appropriate follow-up instructions, dependent upon the injury, as determined by the certified staff.

NON-STUDENT-ATHLETE INJURIES

The Athletic Training Department, in meeting its goal of functioning as part of Bishop McGuinness Catholic High School will, from time to time, serve the needs of non-student-athletes. This may include students, faculty, and staff. All services rendered will be done in accordance with applicable Practice Acts in the State of North Carolina and will be limited to basic first aid needs. Those individuals needing follow-up care will need to seek such care through their PCP's or pediatricians. All individuals reporting to the Athletic Training Room will receive first aid services as

deemed necessary and in accordance with acceptable standards by the Practice Acts of the State of North Carolina. In the event the injured party is a non-student athlete – the appropriate parent/guardian should be notified of the injury. All non-student-athlete injuries requiring care should be documented as per standard guidelines and as such these individuals should then be referred for additional follow-up care to either his/her primary care physician, an Urgent Care/Emergency Room, or an appropriate allied health care professional.

MEDICAL REFERRALS

The certified staff and/or team physician will authorize all referrals for outside medical care. The certified staff will authorize referrals to the team physicians. The team physician or Athletic Trainer will authorize referral to providers other than the team physicians. All injuries/accidents resulting from athletic participation are normally covered according to the injury and accident policies in place. Parent/Guardians are required to provide health insurance coverage for their son/daughter participating in football. Athletes are responsible for providing their own transportation to and from all off-campus medical providers. The athletic training staff will collaborate and coordinate medical referrals with the appropriate health care providers and specialist. Most high schools provide the opportunity for parents and guardians to purchase insurance for sports participation and as such this policy can function as primary coverage or secondary coverage. Secondary schools have catastrophic insurance either purchased through or provided by NCHSAA. For medical claims billed or filed through insurance plans – parents/guardians are responsible for all claim filing procedures.

FINANCIAL COVERAGE OF INJURIES

Sports related injuries occurring to athletes in supervised and scheduled sponsored practices/games of Bishop McGuinness Catholic High School shall be covered by parent/guardian primary insurance. Students may purchase primary insurance for athletics through their school and should consult with the athletic director in this matter. The school insurance can function as secondary accident insurance policy for those students who have primary insurance through their parents/guardians. This school policy is secondary accident insurance coverage and covers only the remaining balance after the athlete's primary insurance has decided of benefits. This policy only covers accidental injuries that occur while the athlete is participating for Bishop McGuinness Catholic High School in a supervised and organized activity. The policy will reject all claims that fall within the following categories of pre-existing injury or a non-athletic injury. All football playing participants must show proof of an insurance policy either through parents/guardians or purchase the school insurance plan. All schools that participate in the NCHSAA carry catastrophic insurance on their athletic programs.

MEDICAL RECORDS

All medical records will be kept in the Athletic Training Room under lock and key at Bishop McGuinness Catholic High School. Injured athletes' medical records are to be updated daily by the athletic training staff. Those injuries or conditions that result in an athlete having his/her activity altered and/or requiring definitive and continued care beyond a 48-hour period must be documented. All patient/student-athlete Protected Health Information (PHI—which includes patient medical & financial information) and any other information of a private or sensitive nature are considered confidential. Confidential information should not be read or discussed by any employee of Bishop McGuinness Catholic High School unless pertaining to his or her specific job requirements. Examples of inappropriate disclosures include:

Violations of this statement include, but are not limited to:

- Accessing information that is not within the scope of your duties
- Misusing, disclosing without proper authorization, or altering confidential information
- Disclosing to another person your sign-on code and/or password for accessing electronic or confidential information or for physical access to restricted areas
- Using another person's sign-on code and/or password for accessing electronic confidential information or for physical access to restricted areas
- Intentional or negligent mishandling or destruction of confidential information

- Leaving a secured application unattended while signed on, or
- Attempting to access a secured application or restricted area without proper authorization or for purposes other than official Bishop McGuinness Catholic High School business
- Failure to safeguard or the misuse of Bishop McGuinness Catholic High School owned equipment/property, or
- Failure to safeguard Bishop McGuinness Catholic High School confidential information on personally owned equipment/property
- Employees discussing or revealing PHI or other confidential information to friends or family members
- Employees discussing or revealing PHI or other confidential information to other employees without a legitimate need to know
- The disclosure of a patient's presence in the office, hospital, or other medical facility, without the patient's consent, to an unauthorized party without a legitimate need to know, that may indicate the nature of the illness and jeopardize confidentiality

The unauthorized disclosure of PHI or other confidential information by employees can subject each individual employee and the practice to civil and criminal liability. Disclosure of PHI or other confidential information to unauthorized persons or unauthorized access to or misuse, theft, destruction, alteration, or sabotage of such information is grounds for immediate disciplinary action up to and including termination.

RELEASING MEDICAL INFORMATION

All athletes participating at Bishop McGuinness Catholic High School shall not have any PHI information made available to collegiate coaches, pro scouts, and the media.

AWAY EVENTS/TRAVEL

All policies shall apply when staff and students travel with teams to away events. This includes policies related to dress and professional conduct. Staff and students should attempt to contact the host athletic training staff and/or host coaching staff as soon after arrival as possible to determine the location of the athletic training room and other facilities which may be necessary for the care of athletic injuries and emergencies. Staff and students should pay particular attention to the procedures necessary to activate the Emergency Medical System, should the need arise. Policies related to the treatment, management, and documentation of injuries should be observed. All injuries evaluated, treated, and managed by anyone in the absence of certified staff should be made known to the certified staff at the earliest possible opportunity.

USE OF ATHLETIC TRAINING ROOM & FACILITIES

Use of the Athletic Training Room is strictly for those individuals involved directly in the BMHS athletic department. Use of the athletic training room by students, staff, alumni, faculty of Bishop McGuinness Catholic High School and outside visitors for treatment and care must have prior approval and be directly supervised by the Bishop McGuinness Catholic High School staff athletic trainers. Those not possessing BOC credentialed and/or NCBATE state licensed may NOT use or access the athletic training room. This medical facility is available to visiting teams on a reciprocal, courtesy basis.

ADVERSE MEDICAL EVENT

Bishop McGuinness Catholic High School Athletic Training Department will attempt to ensure that student-athlete patients and/or their family are properly informed about their health care as allowed. This includes an obligation on the part of all physicians and health care practitioners to inform patients about significant adverse medical events and unanticipated negative outcomes of care that may affect their well-being. Bishop McGuinness Catholic High School Athletic Training does have procedures in place for reporting such adverse medical events. An individual copy of the procedures is provided and maintained on-file.

ATHLETIC TRAINING STUDENT AIDES- No student aides

Athletic training students are to follow policies and procedures as outlined in the XXXX School Athletic Training Student Aide Handbook. The Handbook can be accessed at: (if you have student aides –need to outline their duties and limitations)

ATHLETIC TRAINING EQUIPMENT (practices/games)

The coverage for games, practices or athletic events shall have the appropriate emergency equipment on-site, water, ice and medical kit, student-athlete emergency contact information and either a cell phone or portable radio for communication purposes. Emergency equipment includes but is not limited to AED, crutches, splints, spine-board. Low risk sports will have emergency equipment available as deemed necessary by the athletic training staff in-charge of that sport. The EAP's will be followed as directed (Appendix 4)

ATHLETIC TRAINING ROOM MAINTENANCE

The athletic training room and equipment are cleaned daily. Listed in the athletic training room are the routine cleaning procedures.

Daily Cleaning List:

- Clean Tables (Sanitizing/Disinfecting wipes)
- Clean Bottles
- Clean coolers
- Sweep Floor
- Clean equipment (modalities, scissors) after each use
- Janitors mop in the evenings during daily cleaning for the school

All equipment such as braces, splints etc. are signed out and are to be returned by the athlete when they are no longer needed. All water coolers, ice chests and water bottles are to be cleaned and disinfected daily after use. Towels and pillowcases are to be laundered when use and/or soiled. All modalities are to be cleaned daily and floors mopped or vacuumed. The Bishop McGuinness Catholic High School Exposure Control Plan guidelines will be utilized as appropriate.

INVENTORY, SUPPLY and PURCHASE

The head athletic trainer is responsible for the budgetary needs for the athletic training program. Inventory is conducted each May and December. Supplies, materials, and contracted services are coordinated in accordance with the Bishop McGuinness Catholic High School policies and procedures for purchase and requisitions. No staff member or student can alter or circumvent these regulations without written consent from the Director of Athletics and/or the Principal of Bishop McGuinness Catholic High School. All sports medicine supplies and materials are properly inventoried, stored and or protected as indicated.

MEDICATION POLICY

Terminology

Administering (Definition): is a single unit dose of medication prepackaged or a 24-hour dosage prepackaged.

Administering medications is allowed by certified staff athletic trainers only as permitted by Davidson County School Policy 6.29.3 (https://drive.google.com/file/d/1UxqN8m5Cm_zGBVFHcce2xoY5O6ErKhTE/view)

Dispensing (Definition): preparing and packaging medication for the subsequent use by a patient.

Dispensing is performed by MD, DO, RN, NP, RPT or PA.

During the clinical aspect of the Athletic Training outreach program, athletic training staff will meet medications from time to time. Athletic training staff will not administer any over the counter (OTC) medications without the written permission of a student-athlete's parent or guardian. Parents must complete and have on-file the required Davidson County Schools medication forms.

Prescription medications are prescribed by a physician. This type of medication will only be given to the athlete by the physician for whom the prescription is made. Prescription medications commonly used in athletic training include epinephrine (EpiPen) and albuterol for asthma. Athletes with a history or hyper-sensitivity to allergens are required to carry or have handy their own EpiPen. In an emergent situation, the athletic trainer may have to assist the student-athlete with the EpiPen administration. Athletes with a significant asthma condition maybe required to carry or have handy their own MDI per albuterol or other asthma control medication. In an emergent situation the athletic trainer may have to assist the student-athlete with the asthma MDI administration and/or Epi-pen.

Over the counter (OTC) medications are medications that can be purchased without a prescription from a physician. There are still devastating side effects that can result from improper use of OTC medications. Care should be given before any athlete takes any type or such medication on their own. Athletes who will be at risk of head injury (i.e., football players) should not take any medication prior to practice such as Tylenol, aspirin, or ibuprofen. All medications used by a student athlete care of their own accord must be used appropriately and with due diligence. Whenever possible or feasible, the athletic training staff should ask each student athlete if they have any allergies prior to him/her taking any personal over the counter medications. Athletes should become familiar with the actions, dosage, and warnings associated with the most used medications. All expired medications must be properly disposed of.

FACILITY SAFETY CHECKLIST

The attached Facility Safety Checklist is completed each May and December by the athletic training staff to detect hazards in the athletic training room needing to be serviced or corrected. All current safety precautions and practices in place and that are functioning appropriately are reviewed and strengthened as needed. The Athletic Training Room will adhere to the BOC Facilities Accreditation check list and documentation of such is on-file in the Athletic Trainer's office. The appropriate forms are attached to this policies and procedures document. All hazardous and immediate safety concerns are documented and reported to the Director of Athletics.

STUDENT AIDES/FIRST RESPONDERS:

Students can shadow and observe from the sideline, on the court, on the mat, on the field and in the athletic training room. They can earn CPR/ AED or even first aid certification through the Red Cross or AHA and assist with these skills as needed. They can be taught skills like taping, special tests and your RTP procedures but may not apply them in the clinical setting per managing athletic injuries. They can practice athletic training skills on each other in the athletic training room during down-time. Student Aides may not initiate a rehabilitation program, determining return to play, evaluating an injury, etc. on any student athlete under your watch. Any of these would be a violation of our state practice act. Learning about the administrative component is also an important aspect of the athletic training field. This would include documenting temperature and humidity per the NCHSAA Heat Illness guidelines, recording the names of those receiving treatment in the athletic training room etc. Duties that a student-aid may also assist with include the following:

- Field set up and take down
- Hydration specialization
- Cleaning duties
- Performing inventories

- Stocking kits
- Stocking shelves, taping tables, etc.
- Making ice bags
- Eyes and ears-sideline recognition of an athlete struggling with heat illness, head injury, etc.

Please refer to the following documents as needed for further information:

<https://www.nata.org/sites/default/files/student-aide-statement.pdf>

<https://www.nata.org/sites/default/files/student-aide-letter.pdf>

NOVANT HEALTH

CONCUSSION PROTOCOL

Rev 7/26/18 1:00PM

Concussion Assessment, Management, and Return to Play Guidelines:

The following policy and procedures on neurocognitive baseline testing and subsequent assessment, and the management of concussions including return to play guidelines has been developed in accordance with the Gfeller-Waller Act and the NCHSAA guidelines to provide quality healthcare services and assure the well-being of each student-athlete at the secondary school level. This protocol was developed by the athletic training staff and team physicians in conjunction with the recommendations and guidelines from the NATA Position Statement on the Management of Sport Related Concussion, NCAA Sports Medicine Handbook, NCAA Inter-Association Guidelines for Concussion Management, the Consensus Statement on Concussion in Sport 3rd and 4th International Conference on Concussion in Sport held in Zurich, November 2008 and 2012, 5th International Conference on Concussion in Sport held in Berlin, October 2016

Purpose:

The Novant Health Athletic Trainers and the Primary Care Team Physicians recognize that sport related concussions pose a significant health risk for student-athletes. The Sports Medicine Team has implemented policies and procedures to assess and identify those student-athletes who have suffered a concussion. It is also recognized that baseline neurocognitive testing can provide significant data for assisting in return to competition decisions in student-athletes. This information is especially helpful in those participating in collision and/or contact sports, and/or those athletes who have had a history of prior concussions. Changes from baseline data, along with physical examination, and/or further diagnostic testing will be used in determining when it is safe for a student athlete to return to competition. It is important to note that attending physicians must have either the MD or DO credential. Regarding the Gfeller-Waller Act, a Licensed Health Care Provider (LHCP) is one who is licensed and credentialed as an athletic trainer, physician assistant, nurse practitioner and/or a physician.

Concussion Definition:

Sport related concussion (SRC) is a traumatic brain injury induced by biomechanical forces. Several common features that may be utilized in clinically defining the nature of a concussive head injury include:

- SRC may be caused either by a direct blow to the head, face, neck or elsewhere on the body with an impulsive force transmitted to the head.
- SRC typically results in the rapid onset of short-lived impairment of neurological function that resolves spontaneously. However, in some cases, signs and symptoms evolve over a few minutes to hours.
- SRC may result in neuropathological changes, but the acute clinical signs and symptoms largely reflect a functional disturbance rather than a structural injury and, as such, no abnormality is seen on standard structural neuroimaging studies.
- SRC results in a range of clinical signs and symptoms that may or may not involve loss of consciousness. Resolution of the clinical and cognitive features typically follows a sequential course. However, in some cases symptoms may be prolonged.
- The clinical signs and symptoms cannot be explained by drug, alcohol, or medication use, other injuries (such as cervical injuries, peripheral vestibular dysfunction, etc) or other comorbidities (eg, psychological factors or coexisting medical conditions).
- While we no longer use the terms “mild/moderate/severe” there is clearly evidence that the intensity and duration of symptoms can vary greatly. These symptoms present differently in each athlete and can occur during practice or during competition in any sport. A student-athlete does not have to be “knocked - out” nor does one have to lose

consciousness to have a concussion. Concussion signs and symptoms may worsen in the first 24-48 hours after the initial event.

Education:

Pre-Season Education: Student-Athletes, coaches, ATCs, team physicians, school nurses and Director of Athletics will be educated on the signs, symptoms, and risks associated with concussions.

1. All student-athletes and parents/guardians must read Gfeller-Waller NCHSAA Concussion Information Sheet and sign the Gfeller-Waller NCHSAA Concussion Statement Form acknowledging that:
 - they have read and understand this policy and the Gfeller-Waller NCHSAA Concussion Information Sheet
 - they will accept the responsibility for reporting their injuries and illnesses to the coaches and medical staff, including signs and symptoms of concussions.
2. Concussion Information Sheet distributed to head and assistant coaches/athletic trainers/first responders/school nurses/volunteers must read and sign the attached Coaches Concussion Policy Statement acknowledging that:
 - they have read and understand this policy and the Gfeller-Waller NCHSAA Concussion Information Sheet
 - they will encourage their student-athletes to report any suspected injuries and illnesses to the medical staff, including signs and symptoms of concussions, and that they accept the responsibility for referring any student-athlete suspected of sustaining a concussion to the medical staff
3. Either the director of athletics or his designee will coordinate the distribution of the Gfeller-Waller Concussion materials, any scheduled educational sessions, and the signing, collection, and retention of all the signed statements. The student-athletes' signed statements along with the coaches and medical personnel signed statements will be kept on-file.

Signs and Symptoms of Concussion:

Certified athletic trainers and members of the coaching staff all need to be aware of the signs and symptoms of concussion to properly recognize and intervene on behalf of the student-athlete. One does not “see” a concussion the same as you would see an ankle sprain. While you may notice or recognize some signs/symptoms right away, other symptoms can show up hours or days after the injury.

Concussion Signs/Symptoms Include but Are Not Limited to The Following:

Headache, Confusion, Amnesia, Loss of Consciousness, Balance problems, Dizziness, Double or Blurred Vision, Sensitivity to Light and Noise, Nausea or Vomiting, Feeling Sluggish, Foggy or Groggy, Feeling Irritable, Sleep Disturbances, Concentration or Memory Problems and Slowed Reaction Time.

Baseline Assessment:

Prior to initial participation in a varsity sport, every student-athlete will complete a baseline current symptom evaluation form (Appendix 3). This form is kept on-file by the athletic trainer at each school. Currently Novant Health utilizes and provides the **IMPACT™** concussion management system (www.impacttest.com). The **IMPACT™** system is a Windows-based user-friendly computer program that is designed to test cognitive functioning.

All first-time student-athletes (incoming freshman or transfers) participating in JV or varsity athletics will take the IMPACT Test as scheduled for their team – ideally in their pre-season whenever possible and at a time such testing can be accommodated.

** Athletes who sustain a documented concussion may need to repeat baseline testing after three to six months or before a subsequent season – especially those with complicated or multiple concussion history as determined by the team physician.*

***Athletes who are flagged by the Impact Testing System to have an INVALID Baseline upon initial testing will need to repeat the Impact Test a second time no sooner than 48 hours. If a second baseline is flagged as invalid by the Impact system – then a third baseline test should be performed no sooner than 48 hours. If the third baseline attempt is also flagged invalid by the Impact test, then normative scores per Impact System Data will be utilized per any*

follow-up concussive event evaluation. It is recommended that an athlete with 3 invalid baseline tests seek medical follow-up for neurocognitive evaluation to rule out any underlying medical condition.

Concussion Management and Return to Play Guidelines:

In any circumstance where a concussion is suspected in an athlete, the priority is to remove the athlete from further activity until a thorough sideline assessment or clinical assessment in the athletic training room can be made (see Sideline Management Steps below). The evaluation and assessment must be done by the state licensed and certified athletic training staff (Licensed Health Care Provider - LHCP) or a team physician and/or the physician's designee (Physician Assistant/Nurse Practitioner). An athlete with a concussion will not be allowed to return to play in competition or practice for the remainder of the day. Following a concussion injury, the athlete may need to be withheld from classes or given academic accommodations per the LHCP recommendation. The athlete should be monitored regularly over the initial few hours and not be left alone – he or she should stay with friends, teammates, or family members. The athlete will also be provided with instructions regarding concussion home care until the follow-up evaluation is performed. This information and instruction relating to home care will also be given to a responsible adult (i.e., parent, coach etc.). If there is a question about a concussion diagnosis it is best to err in the direction of conservative treatment until a physician assessment can be arranged. **The cornerstone of concussion management is physical and mental rest until all symptoms resolve, then a graduated return to exertion (to assure that symptoms are not recurrent).** Return to play (RTP) will be a medically documented, supervised and stepwise process under the direction of a Licensed Health Care Provider per the Gfeller-Waller Act as noted in NCHSAA Handbook.

The recommendations in this document for the management of concussion are based on review of the medical literature including, but not limited to, statements by the NCHSAA Gfeller-Waller Guidelines, American Medical Society for Sports Medicine, American Academy of Neurology, NATA Recommendations and Guidelines, Zurich & Berlin Guidelines and the NCAA Manual of Sports Medicine and NCAA Inter-Association Task Force on Concussion Management.

Initial Management Plan May Include All or Some of The Following Diagnostic/Baseline Tests:

Graded Symptom Check List – repeated daily or as deemed necessary by the attending the medical staff. The **SCAT5**– may be repeated every 48 hours or as deemed necessary by the attending medical staff or when baseline scores are achieved at a reasonable time. **IMPACT** – maybe performed no sooner than 48 hours of concussion diagnosis. Further testing based on symptomatology presented and then approximately every 2-3 days after or as team physician directed. The Concussion Recognition Tool -5 (CRT5) may be used to assist or help identify concussion events in athletes.

(https://sportconcussion.com.au/wp-content/uploads/2016/02/Concussion_Recognition_Tool5.pdf)

Sideline Management Steps:

HEAD INJURY EVALUATION

INITIAL EVALUATION:

1. In all situations where a concussion is suspected the first step is to remove the athlete from activity.
2. The athlete should be evaluated for cervical spine trauma, skull trauma and intracranial bleeding especially in the event of a violent/high speed collision; or fall type injury mechanism or presentation of significant symptomatology. The physical exam may include ROM testing, motor, sensory and reflex testing, vital signs, pulse oximetry and BP monitoring as deemed necessary
3. The athlete should be questioned to see if concussion symptoms are present. If concussive symptoms are present, the athlete is removed from competition until cleared by physician. (Proceed to MANAGEMENT.)
4. If they deny concussion symptoms, the athletic trainer should perform a SCAT5 test either on the field, in the athletic training room, in the locker room, at half-time, or post-event as deemed necessary.
5. If the athlete's SCAT5 including the symptom checklist are within normal limits (WNL) and they continue to be free of any signs or symptoms, then they may perform light exertional drills followed by sport specific drills.
6. If the athlete can perform light exertional and sport specific drills **and** does not experience symptoms **and** shows no signs or neurologic findings at 15 minutes the athlete may return to competition that day.
7. If the athlete develops or reports signs/symptoms during #5, proceed to MANAGEMENT.

8. In all circumstances SOAP note documentation should be completed on the involved athlete. The athlete must be followed-up post-event and again the following day. If any signs/symptoms of concussion become evident –then follow-up is required with the athletic trainer and/or team physician and/or associated LHCP as available or deemed necessary. The licensed and certified athletic trainer should communicate and discuss as needed with a LHCP – preferably the team physician regarding management of suspected concussive events.

MANAGEMENT:

1. The athlete is removed from competition for that day.
2. Assess the athlete for worsening symptoms every 10 minutes for the first 30 minutes. Vital signs should also be assessed as needed.
3. An athlete with worsening symptoms, especially worsening headache, nausea/vomiting, increasing confusion, garbled speech, lethargy or extreme sleepiness, trouble using their arms or legs, convulsions or seizure activity should be immediately transported to the emergency room for further evaluation and treatment.
4. In all circumstances SOAP note documentation should be completed on the involved athlete. The athlete should be followed up post-event and again the following day.
5. The athlete should **NOT** return to the current competition/practice that calendar day, even if symptoms completely clear.
6. If vital signs (BP, HR, and Respiration) are WNL, and there is no worsening of symptoms at one hour post-removal from athletic participation and the athlete appears to be in no immediate distress, he/she can be released to go home with a responsible adult for accompaniment and observation after reviewing the Home Care Instruction Sheet for Concussions (Appendix 4).
7. If vital signs are not WNL and the athlete appears in distress – then immediate referral to a local medical facility will be initiated.
8. The athlete should be evaluated by the team physician or a LHCP before any return to play and must enter the Gfeller-Waller Concussion Protocol. Ideally, the Novant Health sports medicine primary care physicians should be the primary referral source for all significant concussion event evaluations.

The student-athlete may be transported to an emergency room for evaluation if he/she experiences any of the following:

1. Prolonged loss of consciousness (> 1 min) or a deteriorating conscious state
2. Persistently diminished or worsening mental status
3. Progressive symptoms (ex. Severe or increasing headache, persistent double vision, increasing restlessness, agitation and combativeness)
4. Glasgow Coma Scale < 13 as indicated on the SCAT5
5. Focal neurological deficit suggesting intracranial trauma
6. Repetitive vomiting
7. Spinal injury, significant neck pain/tenderness and/or tingling, burning or weakness in arms and/or legs
8. Seizures or convulsions

Care Steps for the above: activate the EAP, treat the athlete per cervical spine and serious head injury, follow standard first aid and CPR procedures

IF THERE IS LOSS OF CONSCIOUSNESS OR THERE ARE SIGNS OF NEUROLOGICAL IMPAIRMENT:

1. All athletes with documented loss of consciousness or signs of neurologic impairment shall be considered to have a significant concussion and should be sent to a medical facility for further evaluation unless the team physician (or a local LCHP equivalent in travel situations) deems otherwise.
2. If the athlete remains unconscious, he/she should undergo cervical spine immobilization and be transported by rescue squad to the nearest emergency department.
3. In all circumstances SOAP note documentation should be completed on the involved athlete. The athlete should be followed up post-event and again the following day.
4. The athlete should **NOT** return to the current competition/practice that calendar day, even if symptoms completely clear.
5. The athlete must be evaluated by the team physician before return to play and must enter the Gfeller-

Return to Play Guidelines (RTP):

Return-to-Play is a functional stepwise progression and will follow the Gfeller-Waller Concussion Protocol. This protocol for RTP will not be initiated until the athlete is asymptomatic and a LHCP and/or physician determines that all Impact scores (*if utilized*) are comparable to baseline on all measures. In the presence of compelling evidence, the team physician and/or LHCP has discretion to delay the initiation of the Return-to-Play protocol. If signs or symptoms appear during a functional test, the test will be stopped immediately, and the student-athlete will be monitored until all signs or symptoms resolve. No further functional testing will be performed that day. If symptoms do not resolve, the team physician or his/her designee will be consulted, and appropriate medical attention will be provided. When the student-athlete is again symptom-free, he/she will resume the stepwise progression, starting at the last step that was fully completed before the return of symptoms. Functional Stepwise Progression to the next step will require the athlete to remain symptom-free.

Typical RTP Steps:

- Light aerobic exercise without resistance training (e.g., stationary bike or walking: 20 minutes)
- Moderate aerobic exercise: jogging at a medium pace. Body weight resistance exercises (push-ups, lung walks) with a minimal head rotation x 25 each.
- Sport-specific agility exercises and activity without head impact (e.g., sprints, dribbling, shooting, walk-through, skill enactment activities, etc.) Running at fast pace and incorporating body weight resistance exercises x 50 each.
- Non-contact practice drills – warm up and stretch 10 minutes. Intense non-contact sport specific agility drills x 30-60 minutes
- Unrestricted training/practice (For contact sports – modified and controlled contact drills maybe initiated and then re-assessed if the athlete can return to Full Contact/Full Return to Participation)
- Return-to-competition/full sports participation

Protocol

1. Once self-reported symptoms are clear and the attending medical staff (LHCP) is satisfied with his/her clinical evaluation, the athlete is evaluated with testing that is compared to baseline test performance.
2. When asymptomatic for 1 day at rest AND post-concussion testing is within normal baseline limits – light exertional exercises may be conducted. These exercises include walking, stationary bike peddling or even low intensity jogging (<70% of max predicted heart rate). No resistance training is to be performed. The mode and duration of the exertional exercise maybe dependent upon the sport.
3. If the athlete remains asymptomatic than he/she can begin moderate aerobic exercise: jogging at a medium pace. Body weight resistance exercises (push-ups, lung walks) with a minimal head rotation x 25 each.
4. If the athlete remains asymptomatic the day after the moderate exertional exercises they may proceed with sport-specific activities. These activities would include dribbling, passing, throwing, running and agilities. The primary goal of this phase is to add movement. The mode, intensity, and duration of the non-contact sport activities maybe dependent upon the sport.
5. If the athlete remains asymptomatic after one day of sport-specific activities, then athlete can be involved in non-contact training drills (sport specific movements/drills). The mode, intensity, and duration of the non-contact sport activities maybe dependent upon the sport. The goal of this phase is to increase exercise stress load, change direction, evaluate for coordination, and assure athlete can handle cognitive and physical stress.
6. If the athlete remains asymptomatic after one day of sport-specific activity, and they have been cleared medically, the athlete may return to normal training activities. In collision sports it is suggested that patients undergo contact in a controlled practice environment to assure the athlete remains asymptomatic. The goal of

this phase is to prepare the athlete for normal game play. If the athlete develops concussion signs/symptoms – then the athlete must be referred for physician evaluation.

7. If the athlete has no return of symptoms with the above, they are deemed ready to return to all activities.
8. At any point in the process if the athlete becomes symptomatic on any date or scores on clinical measures a decline – the athlete must be placed at rest and withheld from activity. The team physician will be consulted, and the athlete will at minimum rest for 24 hours and will need to go back to the last tolerated step and progress through each phase again.
9. The athlete also needs to be questioned and/or evaluated for recurrence of symptoms due to mental exertion such as reading, working on a computer, taking notes in class/test taking in class or even watching film for game/practice preparation.
10. Once an athlete with SRC is in the RTP protocol – the steps are documented and signed-off on per the NCHSAA RTP Protocol and kept on-file. When these steps are completed, the LHCP and the athlete's parent/legal guardian must both sign and keep on-file the Return to Play Form. Once these forms are completed and on-file the athlete may at that time return to full athletic participation.

The NH physicians and athletic trainers recognizes that formal assessment including neurocognitive testing may be delayed due to team travel and other difficulties. With that in mind, it is necessary to plan for neurocognitive testing as soon as possible for the student-athlete and to plan for an evaluation with the team physician. Athletes who sustain a documented concussion may need to repeat baseline testing before a subsequent season – especially those with complicated or multiple concussion history.

Return to Learn (RTL)

Return-to-learn is a parallel concept to return-to-play and as such return-to-learn includes:

- Return-to-learn should be managed in a stepwise program that fits the needs of the individual. This could vary from removal from the classroom environment to modifications in academic demands to allow for a rapid and full recovery.
- Return-to-learn guidelines are based on the information that with a concussion, cognitive function is decreased due to an energy deficit occurring due to the injury. The RTL plan will address accommodations needed to promote cognitive rest, address sensitivity to noise and light, and to reduce the exposure to risk of further injury.
- Return-to-learn recommendations are based on consensus statements and other professional organization recommendations.
- Concussion symptoms often interfere with academic ability, the ability to participate in the classroom setting, and function interpersonally with peers. Therefore, the goal of the RTL recommendations is to allow a student-athlete to maximize learning while minimizing aggravating factors that could delay recovery.
- Return-to-learn recommendations should be made within the context of a multi-disciplinary team that includes team physicians, athletic trainers, counseling services, school nurse and 504 coordinators. It is imperative that each team member communicate with each other and notify one another of a concussive event to an athlete.

Cognitive rest also means avoiding potential cognitive stressors such as video games, reading, texting, and watching television. *Driving while still symptomatic per concussion is not advisable should be discouraged.

Suggested recommendations may include but not limited to:

1. If the student-athlete cannot tolerate 30 minutes of light cognitive activity, he or she should remain at home or in a non-stress environment.
2. Once the student-athlete can tolerate more than 30 minutes of cognitive activity without return of symptoms, he/she should return to the classroom in a stepwise manner. Typically, on return, the student may be recommended to limit computer time to 30-60 minutes per day and maximum 20 minutes without a break. Similar recommendations may be made regarding reading and homework.

3. The levels of adjustment needed should be decided by a multi-disciplinary team that may include the team physician, athletic trainer, 504 coordinator or other faculty representative, coach, individual teachers, and psychologist. The level of multi-disciplinary involvement should be made on a case-by-case basis. Any time concussion symptoms worsen with academic challenges there should be a re-evaluation by the team physician and those individuals involved with the athlete's Return to Learn program

Academic Terminology

Many student-athletes who are concussed will likely need only short-term accommodations in the workload and capacity since full recovery occurs within seven to ten days in most concussions. Return-to-learn management becomes more difficult when the student-athlete has ongoing symptoms for greater than two weeks. The types of academic support and assistance may include the following:

Academic adjustment - a student-athlete's academic schedule requires some modification in the first one to two weeks following concussion. This could include extra-time on exams, a temporary delay on taking exams/quizzes, modifications to workload or additional time to turn in required projects. Athletes who have concussive symptoms for greater than two weeks will need re-evaluation by the team physician and/or the Return to Learn multidisciplinary team.

Academic accommodation - If the student-athlete has not recovered in the anticipated period, he or she may require a change in the class schedule. Special arrangements may be required for tests, term papers and projects. Although there is no fixed timeline for academic accommodation, this generally applies to student-athletes who have more prolonged concussion symptoms, or who may be suffering with post-concussion syndrome. Post-concussion syndrome is not the same as prolonged recovery from concussion and should be suspected in any student-athlete who has ongoing symptomatology two or more weeks following concussion. Post-concussion syndrome is a neuro-psychiatric condition that is best managed in a multi-disciplinary manner with active intervention. Passive management such as prolonged physical and cognitive rest is counter-productive in post-concussion syndrome.

Academic modification - a more difficult scenario in which the student-athlete suffers with prolonged cognitive difficulties, which thereby requires a more specialized educational plan, usually within the construct of an individualized education plan. An individualized education plan is a formal educational plan for an individual and is protected under the Individuals with Disabilities Education Act. This plan is more prescriptive than a 504 plan, which refers to Section 504 of the Rehabilitation Act and the Americans with Disabilities Act. A 504 plan covers students who are not eligible for an individualized education plan but who require academic modification because of a documented medical condition.

Resources

Everyone should recognize that concussion symptoms vary widely among athletes, and even within the same individual who may be suffering a repeat concussion. The point person or case manager for the student-athlete who must navigate the dual obligations of academics and athletics will be the 504 Coordinator in conjunction with the teachers, counselors, and school principal. Co-morbid conditions that may further impair recovery such as migraine, attention-deficit hyperactivity disorder, anxiety and depression will be managed by a multi-disciplinary approach as needed which may include the team physician, athletic training staff, coaches, teachers, academic counselors, other medical specialist, and parents. Please Note Appendices 1 and 2 below as they provide examples of accommodations based on patient symptoms and for academic needs that may be utilized in the event of a concussive injury to a student athlete.

Reducing Exposure to Head Trauma

Concussions are common occurrences in sports, but steps can still be made to reduce the exposure rates of sustaining a concussion. Coaches and student-athletes should take a "safety-first" approach to sport:

- Helmets and or protective equipment must be properly fitted and routinely inspected by the athletes and the coaching staff.

- Football and lacrosse should have routine inspections of their helmets, shoulder pads, chin straps by the student athletes for any cracks, defects, deformities or missing protective padding with their equipment.
- Athletes whose sports require a mouthpiece must be required to correctly fit and consistently use this piece of equipment during play.
- Baseball and softball should always wear helmets when batting, running bases and in the on-deck/coaching boxes.
- Swimmers must not dive into shallow water and must follow all safety rules at swimming pools.
- All coaches for contact sports shall teach proper sports techniques including those that involve blocking and tackling methods and should always reinforce avoid leading with the head in contact and taking the head out of contact with other athletes.
- It is recommended that limiting the amount of contact exposures in practice will aid in reducing concussive events.

Conclusion

The Athletic Training staff, coaches and players should all be aware of the signs and symptoms of concussion and should report or evaluate anyone who is suspected of having a concussion. Complicating factors in these patients include prior concussion history, ADD or ADHD or other learning disability, migraines, or other chronic headache conditions. Diagnostic test results along with neurocognitive testing and the physical examination will be utilized by the athletic training staff and the team physician in establishing a timeline for an athlete's safe return to activity. It is important to note that this timeline could last over a period of days to weeks or months, or some may potentially need medical disqualification from athletic participation. Those athletes whose concussive injuries that present with prolonged recovery may need further diagnosis and management. These cases of prolonged recovery may present with but not limited to post-concussion syndrome, migraines, headache disorders, anxiety, mental depression, and even vestibular and ocular dysfunctions.

All concussion cases will be handled on a case-by-case basis. **The decision by the Novant Health Medical Staff for all cases of an athlete's return to activity should be final. The Novant Health Medical Staff will have the authority to remove an athlete with a suspected concussion from any athletic activity including practice and competition and request that he/she seek further consultation for a suspected concussive injury.** Novant Health also recognizes that parents/legal guardians have the right and privilege to seek care with other health care providers not-affiliated with the Novant Sports Medicine providers and as such become responsible through those outside parties to follow the Gfeller-Waller Act guidelines established as required by the NCHSAA for athletic participation following sports related concussion. Failure follow the Gfeller-Waller Act requirements as noted in the NCHSAA by outside medical providers places the middle or high athletic department in violation of NCHSAA rules and become subject to monetary fines and/or athletic program discipline measures.

The Novant Health Athletic Training Department and Sports Medicine Physicians are committed to providing quality health care services for all student-athletes. As such, the Novant Health medical staff is very proactive in the assessment and management of concussions. This action will help limit the risks associated with concussions associated with athletics, and the potential catastrophic and long-term complications experienced by our student-athletes.

Each year, the Novant Health medical staff will review and update the Concussion Management Policy and Protocol. Any changes will be effective on August 1 of that year or earlier as needed per NCHSAA handbook changes.

References:

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Broglio, S.T., Cantu, R.C., Gioia, G.A., Guskiewicz, K.M., Kutcher, J., Palm, M., & Valovich McLeod, T.C. (2014) National Athletic Trainers' Association Position Statement: Management of Sport Concussion. Journal of Athletic Training, 49 (2), 245-265.

5th International Conference on Concussion in Sport held in Berlin, October 2016:
<http://bjsm.bmj.com/content/early/2017/04/28/bjsports-2017-097699>

NCHSAA Concussion Awareness at <https://www.nchsaa.org/parents-students/health-safety/concussion-awareness>

APPENDIX 1	
<i>Example of Accommodation Options Based on Symptom Type</i>	
Headaches	Allow frequent breaks Identify triggers that cause headache to worsen
Sensitivity to Noise (phonophobia)	No physical activity, band, chorus, etc. Avoid lunchroom; eat in quiet setting Avoid attending athletic events, gymnasiums Refrain from using cell phone, headphones/ear buds
Sensitivity to Light (photophobia)	Allow to wear sunglasses Move to area with low-lighting, dimly lit room Avoid seating with direct sunlight from windows Avoid or minimize bright projector/computer screens
Other visual problems i.e., blurred, or double vision saccadic eye movements (tracking) near-point convergence (close-up)	Limit computer use Reduce/shorten reading assignments Record lectures, use auditory learning apps Allow for more listening & discussion vs. Reading Increase font size on computer screens Desktop work only Refrain from texting, video gaming Refrain from watching TV close-up or from a distance
Concentration or Memory (Cognitive) Problem	Place focus on essential academic content/concepts Post-pone major tests or participation in standardized testing Allow extra time for assignments, quizzes Allow extra time to complete tests, projects Reduce class assignments, homework
Sleep Difficulties	Allow frequent rest breaks

APPENDIX 2***Example of Physician Directed Levels of Instructional Modifications and Academic Accommodations***

1. No School (Stay Home/Dorms)	Discourage texting, video gaming, watching TV, using cell phone, listening to music with headphones No homework or computer use Cognitive "shut-down" Use darkened, quiet room
2. Limited School Attendance (Half Days/Part-Time) Maximum Accommodations - Able to tolerate up to 30 minutes mental exertion	Limit/partial class attendance; no physical activity Periodic rest breaks away from class in a quiet area Limit/modify academic classwork Provide extra help; peer note taking No major/standardized testing Provide extra help; peer note taking Extra time for assignments; modify assignments Extra time for quizzes in a quiet area Minimal or no homework
3. Full-Day Attendance (Limit Class Attendance) Moderate Accommodations - Able to tolerate up to 45 minutes mental exertion	No physical activity Limit class attendance in academically challenging classes No major/standardized testing; modified testing Rest periods in classroom as needed Extra time for assignments; quizzes as needed Limited homework, i.e., less than 30 minutes
4. Full Class Attendance Minimal Accommodations - Able to tolerate up to 60 minutes mental exertion	No physical activity Increase return to normal class workload Begin working on missed work/assignments Moderate homework, i.e., less than 60 minutes
5. Full Academics No Accommodations	Resume normal homework assignments Identify essential content and assignments to make up Develop realistic timeline for completing assignments Re-evaluate weekly until assignments are completed

CONCUSSION GRADED SYMPTOM CHECKLIST

Name: _____ Sport: _____

High School: _____ # of known/documented prior concussions: _____

Rate/Score yourself how you feel at this moment on this date: Baseline Date: ____/____/____

DURATION**RATING**
0 to 6 (circle)Comes and Goes
Most of the Time
Constantly

SYMPTOM	YES	NO	None	Mild	Moderate	Severe	
Headache				0 1 2 3 4 5 6			
Pressure in the Head				0 1 2 3 4 5 6			
Neck Pain				0 1 2 3 4 5 6			
Nausea or Vomiting				0 1 2 3 4 5 6			
Dizziness				0 1 2 3 4 5 6			
Blurred Vision				0 1 2 3 4 5 6			
Balance Problems				0 1 2 3 4 5 6			
Sensitive to Light				0 1 2 3 4 5 6			
Sensitive to Noise				0 1 2 3 4 5 6			
Feeling Slowed Down				0 1 2 3 4 5 6			
Feeling like "In a "Fog"				0 1 2 3 4 5 6			
"Don't Feel Right"				0 1 2 3 4 5 6			
Difficulty Concentrating				0 1 2 3 4 5 6			
Difficulty with Remembering				0 1 2 3 4 5 6			
Fatigue or low energy or tire easily				0 1 2 3 4 5 6			
Confusion				0 1 2 3 4 5 6			
Drowsiness				0 1 2 3 4 5 6			
Trouble Falling Asleep (if applicable)				0 1 2 3 4 5 6			
Feeling More Emotional				0 1 2 3 4 5 6			
Irritability (easily angered or upset)				0 1 2 3 4 5 6			
Sadness or Depressed				0 1 2 3 4 5 6			
Nervous or Anxious				0 1 2 3 4 5 6			
Taking Longer to Think				0 1 2 3 4 5 6			
Double Vision				0 1 2 3 4 5 6			
Ringin g in the Ears				0 1 2 3 4 5 6			
Sleeping more or less than usual				0 1 2 3 4 5 6			

Feeling More Frustrated or Impatient			0	1	2	3	4	5	6	
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Appendix 4

CONCUSSION HOME CARE

Rev. 10/27

Athlete's Name: _____ Date: ____/____/____

To Whom It May Concern:

We have reason to believe this athlete has received significant trauma to his/her head, leading us to suspect he/she has the signs and symptoms of a concussion. It may be necessary during your observation period to have this individual seen by a physician. *Concussions normally result in headache, mild dizziness, loss of appetite, drowsiness, sensitivity to loud noises or bright lights, increased irritability, nauseous, difficulty with concentration, feeling "foggy" or "slowed down, memory lapses and hypersensitive emotions!*

HOME MANAGEMENT

1. Home management should consist of constant monitoring of the signs and symptoms listed below. Rest is recommended. Avoid texting, videogames, loud music, bright lights, and excessive TV viewing or reading.
2. Of the utmost importance, **DO NOT GIVE ASPIRIN or IBUPROFEN or MOTRIN or ALEVE or ADVIL** as it could promote internal bleeding.
3. They may take 1-2 TYLENOL (acetaminophen) every 6-8 hours and use an ice pack on head and neck.
4. Sleep is permissible. The athlete should awaken easily by a pinch or tapping at their desired wake-up time. (Ex. To get up for class or breakfast). IF NOT, SEEK MEDICAL ATTENTION/Call 911/EMS.
5. It is important to drink clear liquids for the next eight hours. It is OK to eat a carbohydrate-rich diet.
6. **DO NOT** engage in any physical exercise of any kind until cleared by the medical staff.
7. **DO NOT** drive or operate any kind of motor vehicle.
8. See medical help if the following signs and symptoms listed below occur or become **progressively worse**. **GO TO THE EMERGENCY ROOM/Contact 911 – EMS!!!** Do NOT allow the individual to drive.

Signs & Symptoms

- *Dizziness/Unsteadiness such that the individual cannot stand up or walk without help or assistance
- *Ringing in the ears that progressively worsen **AND/OR** bleeding or fluid from nose and ears
- *Difficulty with speech (incoherent or slurred speech or the inability to talk)
- *Complaints of numbness or weakness or tingling in arms or legs **AND/OR** loss of movement in arms or legs
- *Persistent headache that progressively worsens **OR** increasing neck pain and stiffness
- * Loss of emotional control or irrational behavior or unusual behavior changes
- *Changes in state of consciousness **AND/OR** convulsions or seizures
- *Peculiar eye movement **AND/OR** blurred or double vision that progressively worsens
- *Increased confusion and amnesia: inability to remember simple facts – date of birth, phone number, last meal, etc.
- * Heart rate is less than: 50 beats per minute for an adult
- *Irregular breathing/labored breathing/very shallow breathing **OR** breathing rate is less than 10 breaths per minute
- *Vomiting more than twice *Dilated **AND/OR** unequal pupil size

EMERGENCY NUMBERS: Ambulance/EMS: 911

Please report back to the athletic training room on date: ____/____/____ for follow-up evaluation and care.

Accompanying parent/guardian

Name: _____

Signature: _____

Date: ____/____/____

HEAT ILLNESS & COLD EXPOSURE Policy

HEAT ILLNESS

Fundamentals of Heat Illness Prevention and Management for all sports:

Per the North Carolina High School Athletic Association (NCHSSA guidelines), a Licensed Athletic Trainer or First Responder MUST attend all football practices and games. The best practice for heat illness prevention is appropriate acclimatization and should consist of gradually increasing the amount of time of environmental exposure (heat and humidity) while progressively increasing physical exertion and training activities.

Prevention steps include but not limited to:

- (1) Begin with shorter, less intense practices and training activities, with longer recovery intervals between bouts of activity.
- (2) Minimize protective gear during first several practices and introduce additional uniform and protective gear progressively over successive days. (E.g., in football, helmets only, no shoulder pads).
- (3) Emphasize instruction over conditioning during the first several practices.
- (4) Keeping each athlete's individual level of conditioning and medical status in mind and adjust activity accordingly. Note there is an increased risk of heat injury if the athlete is obese, unfit, has been recently ill (particularly gastrointestinal illness), has a previous history of exertional heat illness, has Sick Cell Trait, or is using certain medications. Players at risk will be identified from their pre-participation examination.
- (5) High temperatures and high humidity are potentially dangerous for athletes. In these conditions, lower the intensity of practices and increase the frequency and duration of rest breaks, and reducing uniform and protective equipment are recommendations to all coaches. Monitoring all players more closely as conditions are increasingly warm/humid, especially if there is a change in weather from the previous few days. ALL athletes are encouraged to begin practices and training activities adequately hydrated.
- (6) Recognize early signs of distress and developing exertional heat illness (weakness, nausea/vomiting, paleness, headache, lightheadedness). Promptly remove from activity and treat appropriately.
- (7) Recognize more serious signs of exertional heat illness (clumsiness, confusion, stumbling, collapse, obvious behavioral changes and/or other central nervous system problems), immediately stop activity, begin rapid cooling, and activate the Emergency Medical System.
- (8) Prior to the season all coaches, athletic training personnel and first responders working with the team will review, the signs and symptoms of heat illness and the emergency action plan.
- (9) A Wet Bulb Globe Temperature (WBGT) chart will be available at practices and contests.
- (10) Supplies to assess WBGT (or alternatively, heat and humidity on site), to assess core temperature, and to provide for rapid cooling should be on-site for all practices and games as environmental conditions require

Acclimatization (Football) per NCHSAA:

- (a) Days 1–5 are the first formal practices. No more than 1 practice occurs per day.
- (b) Total practice time should not exceed 3 hours in any 1 day.
- (c) 1-hour maximum walk-through is permitted on days 1–5, however there must be a minimum 3-hour break in a cool environment between practice and walk-through (or vice versa).

(d) During days 1–2 of first formal practices, a helmet should be the only protective equipment permitted (if applicable). During days 3–5, only helmets and shoulder pads should be worn (if applicable). Beginning on day 6, all protective equipment may be worn, and full contact may begin.

(1) Football only: on days 3–5, contact with blocking sleds and tackling dummies may be initiated.

(2) Full-contact sports: 100% live action drills should begin no earlier than day 6.

(3) Day 6–14, double-practice days must be followed by a single-practice day. On single-practice days, 1 walk-through is permitted, separated from the practice by at least 3 hours of continuous rest. When a double-practice day is followed by a rest day, another double practice day is permitted after the rest day.

(4) On a double-practice day, neither practice day should exceed 3 hours in duration, and no more than 5 total hours of practice in the day. During the 2-hour practice, there can be NO live action. Warm-up, stretching, cool-down, walk-through, conditioning, and weight-room activities are included as part of the practice time. The 2 practices should be separated by at least 3 continuous hours in a cool environment.

Prevention of Heat Illness:

(a) Wet Bulb Globe Temperature (WBGT) considers the combined effects of air temperature, humidity, and solar radiation on the human body. WBGT should be measured (using a scientifically approved device) for all sports when student-athletes may be at risk for exertional heat illness (EHI). WBGT should be accessed every hour beginning 30 minutes before the beginning of practice.

(b) As WBGT increases, minimize clothing and equipment.

(c) Hydration – During times of warm and hot weather, it is important that athletes maintain hydration. It has been shown that less than 2% loss of body weight can reduce the capacity for exercise in an individual. Athletes preparing to train in the heat must hydrate themselves before, during, and after competition with water and when available sodium and electrolyte-containing drinks such as Gatorade. Unlimited water will be available to athletes at all practices and competitions. During times of practicing in high-risk temperatures, water and rest breaks should be given more frequently and practice times and intensity should be adjusted accordingly.

Prior to Exercise: All athletes should be encouraged to drink 17 to 20 fluid ounces of water or sports beverage 2-3 hours before exercise. Ten to twenty minutes before the beginning of practice or competition, athletes should be encouraged to drink an additional 7-10 fluid ounces of water or sports beverage.

During Exercise: Encourage athletes are encouraged to drink early and often. Ideally, they should drink 7-10 fluid ounces or sports drink every 10-20 minutes. It is important to stress to the athletes to drink prior to becoming thirsty. An athlete who is thirsty may already be in the early stages of dehydration.

After Exercise: Athletes are encouraged to replace any fluid loss due to sweating within 2 hours from the end of exercise. This rehydration should include water, carbohydrates, and electrolytes to allow the immediate return of physiologic function. Ideally, they should drink 20-24 fluid ounces for every pound of weight lost. Athletes should carry a bottle of water with him/her to drink out between practices and lightly salt food to taste at meals and get “rest” during the rest periods between practices and at night.

Additionally, urine color charts if available will be posted in the bathroom areas or the team locker rooms to assist the student athletes in checking their hydration levels.

****Sport beverages should ideally contain a carbohydrate level of no more than 8%. A higher carbohydrate level can retard fluid absorption and cause stomach problems.**

****Fruit juices, carbohydrate gels, and carbonated beverages should not be recommended as the sole rehydration beverage of choice. Beverages containing caffeine, alcohol, or carbonation should be avoided and discouraged due to their diuretic effects and decreased fluid retention. Coaches should provide unlimited drinking opportunities during hotter practices. NEVER withhold water from athletes.**

(d) Pre- and post-practice weigh-ins SHOULD be conducted. NOTE: an athlete who is not within 3% of the previous pre-practice weight should be withheld from practice. These athletes should be counseled on the importance of re-hydrating. Pre- and post-practice weigh-ins are recommended for all sports participating during periods of high heat and humidity.

(e) If WBGT is at 90 or above suspend practice; contests may continue but must include mandatory breaks as directed by game-day administrator.

WBGT Index and Athletic Activity Chart	
WBGT Index (F)	Athletic Activity Guidelines
Less than 80	<i>Unlimited activity with primary cautions for new or unconditioned athletes or extreme exertion; schedule mandatory rest/water breaks (5 min water/rest break every 30 min)</i>
80 - 84.9	<i>Normal practice for athletes; closely monitor new or unconditioned athletes and all athletes during extreme exertion. Schedule mandatory rest /water breaks. (5 min water/rest break every 25 min)</i>
85 - 87.9	New or unconditioned athletes should have reduced intensity practice and modifications in clothing. Well-conditioned athletes should have more frequent rest breaks and hydration as well as cautious monitoring for symptoms of heat illness. Schedule frequent mandatory rest/water breaks. (5 min water/rest break every 20 min) Have cold or ice immersion pool on site for practice.
88 - 89.9	All athletes must be under constant observation and supervision. Remove pads and equipment. Schedule frequent mandatory rest/water breaks. (5 min water/rest break every 15 min) Have cold or ice immersion pool on site for practice.
90 or Above	SUSPEND PRACTICE/MUST INCLUDE MANDATORY BREAKS AS DIRECTED BY GAMEDAY ADMINISTRATOR DURING CONTEST.

The WBGT can be measured with a WBGT meter. The calculation for the determination of WBGT is:

WBGT = .7 (Wet Bulb Temperature) + .2 (Black Globe Temperature) + .1 (Dry Bulb Temperature).

*When no BGT is available to use: **WBGT = .7(Wet Bulb Temp) + .3(Dry Bulb Temp)***

NOAA's National Weather Service Heat Index Scale

Heat Index < 80 safe for normal activity (GREEN)

Heat Index 80-90 is a Yellow Zone – Caution as fatigue is possible

Heat Index 90-103 is Extreme Caution – heat cramps and heat exhaustion are possible

Heat Index 104-124 is Red Zone – sunstroke, heat cramps and heat exhaustion likely

Heat Index 125> is Black Zone - sunstroke, heat cramps and heat exhaustion likely with continued exposure

<http://www.wpc.ncep.noaa.gov/html/heatindex.shtml>

http://www.nws.noaa.gov/om/heat/heat_index.shtml

Recognition of Heat Illness:

(a) Heat cramps – The first stage of heat illness is heat cramping and is not life-threatening. It can be caused by dehydration, electrolyte imbalance, or fatigue. Signs and symptoms of heat cramps include Acute, painful, and involuntary muscle contraction and mild dehydration.

(b) Heat Exhaustion generally include the following: Athlete has obvious difficulty continuing with exercise; Body temperature is usually 101 to 104°F (38.3 to 40.0°C) at the time of collapse or need to drop out of activity; No significant dysfunction of the central nervous system is present (e.g., seizure, altered consciousness, persistent delirium) Should any central nervous system dysfunction develops, such as mild confusion, it resolves quickly with rest and cooling.; Tachycardia (very fast heart rate) and hypotension (low blood pressure); Extreme weakness; Dehydration and electrolyte losses; Ataxia (loss of muscle control) and coordination problems, syncope (passing out), light-

headedness; Profuse sweating, pallor (paleness), “prickly heat” sensations; Headache; Abdominal cramps, nausea, vomiting, diarrhea; Persistent muscle cramps

(c) Heat Stroke has two main criteria for diagnosis - Rectal temperature above 104°F (40°C), measured immediately following collapse during strenuous activity AND Central Nervous System dysfunction with possible symptoms and signs: disorientation, headache, irrational behavior, irritability, emotional instability, confusion, altered consciousness, coma, or seizure. Most patients are tachycardic and hypotensive; Patients with heat stroke may also exhibit Hyperventilation, Dizziness, Nausea, Vomiting, Diarrhea, Weakness, Profuse sweating, Dehydration, Dry mouth, Thirst, Muscle cramps, Loss of muscle function, and Ataxia. The absence of sweating with heat stroke is not typical and usually indicates additional medical issues.

(d) * Exertional Hyponatremia – Hyponatremia is a rare condition caused by decreased sodium in the body and over-hydration. Signs and symptoms of exertional hyponatremia: Core Temperature <104°F, nausea, vomiting, swelling of the extremities, progressive headache, confusion, significant mental compromise, lethargy, altered consciousness, apathy, pulmonary edema, cerebral edema, seizures, and coma.

Management of Heat Illness:

Heat cramps: Activity should be stopped, and the athlete will be given water and if available sodium-containing fluids such as Gatorade. The certified athletic trainer can begin mild stretching and massage of the muscle spasms while the athlete is lying down. The involved muscle or body part may also have ice bags applied to the area. Activity may be resumed at the discretion of the certified athletic trainer.

Heat syncope – Activity should be stopped, and athlete will be given water and if available sodium-containing fluids upon waking. Athlete should be placed in a shaded, cool area and allowed to lie down. Ice packs can be given to the athlete to help cool down. The athlete may also upon waking can be placed next to a mister unit, placed in a cold tub for immersion or a cold shower. The athlete will be held out the remainder of the day and further activity may be resumed the following day at the discretion of the certified athletic trainer and/or team physician.

Heat exhaustion – Activity should be stopped, and athlete will be given water and if available sodium-containing fluids. Athlete should be taken to a shaded, cool area and have excess clothing and equipment removed. The athlete will be cooled with a cooling fan/mister, cold towels, ice bags, or cold-water tub immersion as necessary. The certified athletic trainer will assess cognitive function and vital signs. If necessary, the athlete will be referred to the team physician, an urgent care facility and/or emergency room. Activity may be resumed at the discretion of the certified athletic trainer and/or team physician if contacted.

The primary goal of management of heat illness is to reduce core body temperature as quickly as possible. When exertional heat stroke is suspected, immediately cooling is initiated, and then activation of the emergency medical system. Remember “Cool First, Transport Second”. Removal of all equipment and excess clothing prior to cold tub immersion/cooling is highly recommended

While immersing the athlete in a tub of cold water (the colder the better), the water can be stirred vigorously during the cooling process while adding additional ice or cold water to the tub. Cooling can be ceased when rectal temperature reaches 101 to 102°F (38.3 to 38.9°C). Should an immersion pool be unavailable or in cases of heat exhaustion, the use these cooling methods can be applied: Placing icepacks at head, neck, axillae, and groin; Bathing face and trunk with iced or tepid water; Fanning the athlete to help the cooling process and moving the athlete to a shaded or air-conditioned area if available near the practice site. Monitor vital signs, heart rate, respiratory rate, blood pressure, pulse oximetry if available and mental status continually. Maintain patient safety.

Activity may be resumed at the direction of the team physician due to the concern of prolonged impaired thermoregulation and CNS dysfunction.

* Exertional Hyponatremia – Activity must be stopped immediately, and the emergency action plan/response system initiated. The athlete can be given sodium-containing fluids only.

COLD EXPOSURE:

Any individual can lose body heat when exposed to cold air, but when the physically active cannot maintain heat, cold exposure can be uncomfortable, impair performance and may be life-threatening. Cold stress may develop as the result of environmental or non-environmental factors. The NATA position statement (2008) states that injuries from cold exposure are due to a combination of low air or water temperatures and the influence of wind on the body's ability to maintain a normo-thermic core temperature, due to localized exposure of extremities to cold air or surface. Non-environmental factors that may result in the signs and symptoms of cold stress include (but are not limited to) previous cold weather injury (CWI), race, geological origin, ambient temperature, use of medications, clothing attire, fatigue, hydration, age, activity, body size/composition, aerobic fitness level, acclimatization, and low caloric intake. Nicotine, alcohol, and other drugs may also contribute to how a person adapts to the stresses of cold.

Cold Injuries include the following:

1. Hypothermia - is defined as a decrease in core body temperature below 95°F
2. Frostbite is actual freezing of body tissues and is a localized response to a cold, dry environment, yet moisture from sweating may exacerbate frostbite due to increased tissue cooling.
3. Chilblain, also known as "pernio", is an injury associated with extended exposure (1–5 hours) to cold, wet conditions. Chilblain is an exaggerated or uncharacteristic inflammatory response to cold exposure.
4. Immersion (Trench) Foot. Immersion foot typically occurs with prolonged exposure (12 hours to 4 days) to cold, wet conditions, usually in temperatures ranging from 32°F to 65°F

Important factors to decrease the possibility of cold exposure injury or illness are:

- Wear appropriate clothing (dress in layers and try to stay dry),
- Maintain energy levels (via the use of meals, energy snacks and carbohydrate/electrolyte drinks),
- Stay hydrated but avoid alcohol, caffeine, nicotine, and other drugs that cause water loss, vasodilatation, or vasoconstriction of skin vessels
- Minimize fatigue and exhaustion as these deplete energy levels,
- Warm-up properly prior to activity,
- Use a partner during cold weather workouts.

Cold Exposure:

- Breathing of cold air can trigger asthma attack (bronchospasm)
- Coughing, chest tightness, burning sensation in throat and nasal passage
- Reduction of strength, power, endurance, and aerobic activity
- Core body temperature reduction, causing a reduction of motor output

Cold Recognition:

- Shivering, a means for the body to generate heat
- Excessive shivering contributes to fatigue, loss of motor skills
- Numbness and pain in fingers, toes, ears, and exposed facial tissue
- Drop in core temperature; athlete exhibits sluggishness, slowed speech, disoriented

Outside participation limited:

*When temperature or wind-chill (which is lower than actual temperature) reaches 25° F. Frostbite can occur in 30 minutes or less! Limitations will be based on the NOAA wind chill and sport participation chart as set out by the NATA Environmental Cold Injuries position statement.

RECOMMENDATIONS AS A BEST PRACTICE:

****Termination of outside participation:**

When temperature or wind-chill (which is lower than actual temperature) reaches 15° F.

BEST PRACTICE RECOMMENDATIONS & GUIDELINES FOR PRACTICE & CONDITIONING SESSIONS OUTDOORS

32° F - 25° F: practice or conditioning sessions outside must be limited to NO more than 60 minutes followed by a 10-minute warming period inside an enclosed structure or building before returning outside. The total exposure time outside can be no more than 120 minutes.

- Athletes must be aware of potential cold injury and notify personnel of the potential for cold exposure and frostbite
- Athletes are to cover all exposed skin as possible

24° F - 16° F: practice or conditioning sessions outside must be limited to NO more than 30 minutes followed by a 15-minute warming period inside an enclosed structure or building before returning outside. The total exposure time outside can be no more than 60 minutes.

- Athletes must be aware of potential cold injury and notify personnel of the potential for cold exposure and frostbite
- Athletes are to cover all exposed skin as possible

15° F – and below: NO practice or conditioning session may take place outside

CLOTHING:

Clothing is one of the most important parts of keeping the athlete's body warm. Athletes should dress in layers and try and stay dry. Layers can be added or removed depending on temperature, activity and wind-chill. Athletes should layer themselves with wicking fabric next to the body, followed by lightweight pile or wool layers for warmth. Athletes should use a wind block garment to avoid wind-chill during workouts. Heat loss from the head and neck may be as much as 50% of total heat loss; therefore, the head and neck should be covered during cold conditions. Other extremities should be always covered to protect from the wind-chill. Gloves, hats, and scarves should be used. Protecting the ears and nose is equally important. No one should be wearing short sleeves outside in cold weather.

First Aid: Cold Exposure

Intense cold can freeze the water in the body's cells (**frostbite**). Over time, exposure to cold may cause the body's overall temperature to drop (**hypothermia**). The result can be death. The brain carries a temperature regulator that keeps the body near a healthy 98°F. But prolonged exposure to extreme cold may confuse this natural thermostat. Remember: When body temperature goes way out of line, trouble isn't far behind.

1. Raise Body Temperature

- **In case of frostbite**, wrap the area in a soft, loose cloth and seek medical attention **right away**. If medical care is not nearby, hold the affected area under warm, but not scalding, water until normal skin color returns. **Don't** cause additional tissue damage by rubbing the area affected by frostbite.
- **In case of hypothermia**, wrap him or her in warm, dry blankets. Be sure to remove any wet clothing first.

2. Give Warm Liquids

- Provide warm liquids if the person is alert and aware of his or her surroundings. Tea or hot soups are good choices.

3. Seek medical help if any of the following is true:

- The person's fingers, toes, nose, or ears are numb.
- The affected body part looks yellow-white or patchy blue.

4. Call 911 immediately if the victim has any of the following:

- Exceptionally cold skin
- Drowsiness, disorientation, or loss of consciousness
- Loss of muscle control
- While you wait for help reassure the person, assess vital signs, and treat for shock or provide rescue breathing and/or CPR in needed

LIGHTNING & TORNADO POLICY

“Lightning is the most consistent and significant weather hazard that may affect intercollegiate athletics. Within the United States, the National Oceanographic and Atmospheric Administration (NOAA) estimated those 60-70 fatalities and about 10 times as many injuries occur from lightning strikes each year. While the probability of being struck by lightning is low, the odds are significantly greater when a storm is in the area and the proper safety precautions are not followed.”

- Excerpt from the NCAA Guideline (1d Lightning Safety) from the Sports Medicine Handbook

NFHS PROACTIVE PLANNING:

1. Assign staff to monitor local weather conditions before and during practices and contests.
 2. Develop an evacuation plan, including identification of appropriate nearby safer areas and determine the amount of time needed to get everyone to a designated safer area:
 - a. A designated safer place is a substantial building with plumbing and wiring where people live or work, such as a school, gymnasium, or library. An alternate safer place from the threat of lightning is a fully enclosed (not convertible or soft top) metal car or school bus.
 3. Develop criteria for suspension and resumption of play:
 - a. When thunder is heard or lightning is seen*, the leading edge of the thunderstorm is close enough to strike your location with lightning. Suspend play for at least 30 minutes and vacate the outdoor activity to the previously designated safer location immediately.
 - b. 30-minute rule. Once play has been suspended, wait at least 30 minutes after the last thunder is heard or lightning is witnessed* prior to resuming play.
 - c. Any subsequent thunder or lightning* after the beginning of the 30-minute count will reset the clock and another 30-minute count should begin.
 - d. When lightning-detection devices or mobile phone apps are available, this technology could be used to assist in deciding to suspend play if a lightning strike is noted to be within 10 miles of the event location. However, you should never depend on the reliability of these devices and, thus, hearing thunder or seeing lightning* should always take precedence over information from a mobile app or lightning-detection device.
- * – At night, under certain atmospheric conditions, lightning flashes may be seen from distant storms. In these cases, it may be safe to continue an event. If no thunder can be heard and the flashes are low on the horizon, the storm may not pose a threat. Independently verified lightning detection information would help eliminate any uncertainty.
4. Review the lightning safety policy annually with all administrators, coaches and game personnel and train all personnel.
 5. Inform student-athletes and their parents of the lightning policy at start of the season

Forsyth County School Policy regarding Lightning:

Game day administrator monitors possible threatening weather to activate the prearranged safety plan for participants and spectators. Game day administrator should have knowledge of possible watches and warnings. To activate the safety plan, the following should act as a minimum threshold:

1. Flash to bang less than 30 seconds between seeing the lightning flash and hearing the associated thunder.
2. Use of smart phone weather app (Ex. Weather Bug). If app indicates lightning strike is 10 miles or less.
3. Once play has stopped due to lightning – follow NCHSSAA/NFHS 30-minute rule.

**Best Practice when using a weather monitoring device is to have the alarm/warning set for 10 miles and as always if you see lightning or hear thunder clear the area and re-assess continued activity!*

CHAIN OF COMMAND:

- The responsibility of removing athletes from a practice/scrimmage due to the threat of lightning lies with head coach or assistant coach in-charge of that sport/activity.
- The Bishop McGuinness High School staff athletic trainer(s) present will monitor the weather and advise the coach on the situation.
- The responsibility of removing athletes from a game/contest area due to threat of weather/lightning lies with the official/referee or umpire in charge and/or the game administrator in-charge. If no game day administrator is available or identified, the head coach will be designated and recorded as the game day administrator.
- The Bishop McGuinness High School staff athletic trainer(s) present will inform and advise the official/referee or umpire in charge, the visiting team's athletic trainer or head coach of the lightning policy.

MEANS OF MONITORING THE WEATHER

- The "Weather Bug App" or other cellular notification will be used to monitor weather and to attain/receive inclement weather and lightning notifications.
- Computer real-time weather monitoring (weather channel and local Doppler Radar reports) are utilized whenever possible as an adjunct for information to aid in the decision-making process.
- Flash-to-Bang Count: The number of seconds which pass between a lightning strike (flash) and the following sound of thunder (bang). The number of seconds between the flash and the bang are divided by 5 – with the resulting number approximating in distance (miles) from the practice/game area to the lightning strike (flash).
- When the danger or threat of lightning becomes apparent at the outdoor venues – the athletic training staff will sound a warning/give direction for coaches and athletes to immediately leave the field. A verbal warning will also be given to the coaches regarding the danger of lightning being present when the 15-mile and 12-mile lightning alerts have been received. Suspension of athletic activity will occur when lightning is at or within 10 miles.

SAFE LOCATIONS FROM LIGHTNING HAZARDS

- Any fully enclosed substantial building; ideally with plumbing and electrical wiring and telephone services which in "grounding" the building.
- If a substantial building is NOT available, a fully enclosed vehicle with a metal roof and the windows completely enclosed is a reasonable alternative.

- Cellular or cordless phones should be used to summon help during a thunderstorm as they are a safer alternative to land-line telephones.
- Safe Locations include Bishop McGuinness High School (main building)

UNSAFE LOCATIONS FROM LIGHTNING HAZARDS

- Small structures such as rain or picnic shelters, batting cages, bleachers, video-filming towers, dugouts, or athletic storage sheds should be avoided during thunderstorms.
- Convertible vehicles, bleachers and golf carts/Gators do not provide a high level of protection and cannot be considered safe from lightning.
- Indoor and outdoor pools must be evacuated, and all showers turned off during thunderstorms along with therapeutic electrical modalities.
- Locker-room shower areas, swimming pool areas (indoor/outdoor), land-line telephones and electric appliances are also unsafe due to the possible contact with current carrying conduction.

IF NO SAFE LOCATION IS AVAILABLE (Last Resort)

- Find a thick grove of small trees surrounded by taller trees or a dry ditch.
- Stay away from the tallest trees or objects (ex. light poles/flag poles), metal objects (ex. fences or bleachers), individual trees, standing pools of water, air conditioning units and open fields.
- Assume a crouched position on the ground with only the balls of your feet touching the ground, head lowered and cover your ears. **DO NOT lie flat!!**
- A person who feels his or her hair stand on end or skin tingle should immediately assume the position noted above.

SUSPENSION and RESUMPTION of ATHLETIC ACTIVITY

- Suspension of athletic activity should occur when lightning is at or within 10 miles or the Flash to Bang Count reaches 30 seconds. **LIST YOUR SCHOOL RULES**
- Flash to Bang Count can be used in conjunction with the Weather Channel Weather APP and local weather reports enable a sound decision to be made.
- When thunder is heard or a cloud-to-ground lightning bolt is seen, the leading edge of the thunderstorm is close enough to strike your location with lightning. Suspend play for thirty (30) minutes and take shelter immediately.
- Thirty-minute rule. Once play has been suspended, wait at least 30 minutes after the last thunder is heard or flash of lightning is witnessed prior to resuming play or when the lightning detection system/application used gives the official “all clear” notification.
- Resumption of activity should not occur until 30 minutes after the last lightning flash is seen and when Brittany Price, MS, LAT,ATC gives the ALL CLEAR usually after lightning has not occurred within the 10-mile radius of the Bishop McGuinness High School campus. Any subsequent thunder or lightning after the beginning of the 30-minute count will reset the clock and another 30-minute count should begin.

OBLIGATION TO WARN

- According to a basic principle of tort law, an individual has a duty to warn others of dangers that may or may not be obvious to a guest of that person.
- A public address message should be given warning spectators of Bishop McGuinness High School events if lightning activity becomes an imminent danger in the immediate area. Evacuation recommendations should be provided.
- Lightning safety information and tips should be published in game programs and media guides.

PRE-HOSPITAL CARE of LIGHTNING STRIKE VICTIMS

- Activate the local emergency management system (911).
- Lightning strike victims do not carry a charge and are safe to touch/assess.
- Make sure the scene is safe, before you move the victim to a safe location.
- Provide CPR, Airway management, Oxygen administration, AED application as needed per primary survey.
- Secondary survey should include evaluating and treating for common injuries from lightning strikes: hypothermia, shock, fractures, burns and concussion.

ATHLETIC FACILITY SAFE ZONES FOR LIGHTNING

M/W Tennis: Bus

Softball: __Bus and/or Bishop McGuinness High School_ (NOT the dugouts)

Baseball: _ Bus and/or Bishop McGuinness High School _ (NOT the dugouts)

M & W Lacrosse: Bus and/or Bishop McGuinness High School

M & W Soccer: Bus and/or Bishop McGuinness High School

Football: Bus and/or Bishop McGuinness High School

M & W Cross Country: Bus

M & W Golf: Club House

Cheerleading: Bishop McGuinness High School

*M & W Swimming: MUST get out of the pool

Night Lightning/Heat Lightning.

* – At night, under certain atmospheric conditions, lightning flashes may be seen from distant storms. The flashes of light are believed to be the reflection of distant lightning on high clouds. In these cases, it may be safe to continue an event. If no thunder can be heard and the flashes are low on the horizon, the storm may not pose a threat. Independently verified lightning detection information would help eliminate any uncertainty.

NCHSAA Guidelines:

https://www.nchsaa.org/sites/default/files/attachments/guidelines_on_handling_practices_contests_during_lightning_thunder_disturbances_march_2018.pdf

TORNADO SAFETY TIPS

Funnel clouds have been observed on every continent except Antarctica. The United States has significantly more than the rest of the world because of low-lying geography and a climate that breeds strong thunderstorms. With wind speeds up to 320 miles per hour, tornadoes kill about 60 people every year in the United States when uprooted trees and debris turn into deadly missiles.

Tornado signs:

- A sickly greenish or greenish black color to the sky.
- If there is a watch or warning posted, then the fall of hail should be considered as a real danger sign. Hail can be common in some areas, however, and usually has no tornadic activity along with it.
- A strange quiet that occurs within or shortly after the thunderstorm.
- Clouds moving by very fast, especially in a rotating pattern or converging toward one area of the sky.
- A sound a little like a waterfall or rushing air at first but turning into a roar as it comes closer. The sound of a tornado has been likened to that of both railroad trains and jets.
- Debris dropping from the sky.
- An obvious "funnel-shaped" cloud that is rotating, or debris such as branches or leaves being pulled upwards, even if no funnel cloud is visible.

SAFETY TIPS:

1. Determine the best locations for shelter at home, school, and work.

The safest location is always a basement, below the deadly wind and projectile objects. If you can't go underground, find a small interior room or hallway on the lowest level of the building. If there is no basement, go to the center of an interior room on the lowest level (closet, interior hallway) away from corners, windows, doors, and outside walls. Put as many walls as possible between you and the outside. Get under a sturdy table and use your arms to protect your head and neck. Do not open windows.

2. A tornado warning means a tornado has been “spotted”.

3. A tornado watch means weather conditions are “favorable” for tornadoes to occur

4. Know how your community sends its warnings. If it's a siren, stay inside and take cover. Know where the designated shelters are in the buildings where you spend your time.

6. Stay away from windows. Shards of glass can be deadly when severe winds damage windows. You can eliminate this risk if you make sure your shelter area is free of windows. If this isn't possible, protect yourself with a heavy blanket or mattress.

7. Vehicles - In a car or truck: Vehicles are extremely dangerous in a tornado. Get out and seek shelter in a sturdy building. If in the open country, run to low ground away from any cars (which may roll over on you). Lie flat and face-down, protecting the back of your head with your arms.

8. In the open outdoors: If possible, seek shelter in a sturdy building. If not, lie flat and face-down on low ground, protecting the back of your head with your arms. Get as far away from trees and cars as you can; they may be blown onto you in a tornado.

9. Spectators: As with Lightning there is an obligation to warn. A public address message should be given warning spectators of Bishop McGuinness High School events if lightning activity becomes an imminent danger in the immediate area. Evacuation recommendations should be provided. Tornado safety information and tips should be published in game programs and media guides.

TORNADO SHELTER ZONES per ATHLETIC FACILITIES (Appendix 4)

Cardiac Care & AED Policy

Sudden death in young athletes is a rare but tragic event with a rate of 1-2 deaths per 200,000 athletes annually. Physicals/Pre-Participation exams are critical. Pre-participation exams are required for all Davidson County athletes before they are cleared to participate in sports. The pre-participation exam must be carried out by a licensed physician MD/DO or his designee. The NCHSAA Sports Participation Form includes an assessment of cardiac risk factors.

<https://www.nchsaa.org/sites/default/files/attachments/Pre-ParticipationForm2017-18-AugRev.pdf>

Electrocardiograms are not required in preseason screenings at this time nor are they universally endorsed by all cardiology specialty groups and associations. Upon review of the NCHSAA Sports Participation Form by the athletic training staff and/or team physicians, those athletes identified as having potential cardiac concerns or a family history of cardiac concerns maybe be required to undergo EKG screening or seek additional cardiology referral and subsequent clearance to participate in athletics. In certain situations,/cases as designated or noted by the team physician and/or attending cardiologist, some levels of athletic participation may be continued or permitted until such time the secondary or additional testing/diagnostic studies determine the level of participation that should be allowed.

AEDs are easily accessible in all locations used for athletics, including any areas used for strength training or conditioning, as well as the gymnasiums and playing fields. Access to an AED is under 3 minutes in the event of an emergency. The AEDs undergo a monthly inspection, and these are kept on file in the athletic training room.

Monthly AED Checklist

Rev. 1/11/18

High School: _____ Date: ____/____/____

AED Brand/Model: _____ AED Serial # _____

✓ **Is the status indicator light green or flashing green?** *(Pending brand could be different color)*

Yes () = Great! Your AED is working properly and does not need maintenance currently

No () = Contact support

✓ **Is the AED "chirping or beeping"?**

No () = Great! Your AED is working properly and does not need maintenance currently

Yes () = Contact support

✓ **Are the pads (and backup pads if available) within expiration?**

No () = Need to order replacement parts Pad Expiration Date: ____/____/____

Yes () = Great!

✓ **Is the battery (and backup battery if available) within expiration?**

No () = Need to order replacement parts Battery Expiration Date: ____/____/____

Yes () = Great!

✓ **Is the AED visibly damaged?**

Yes () = Contact support No () = Great!

✓ **Is the AED clear of debris and moisture?**

Yes () = Great!

No () = Please remove the debris, dry the area and check that the AED's status indicator light is green and/or flashing green. If it is not flashing green, contact support

✓ **Is the AED Supply Kit in good order?**

Yes () = Great!

No () = Contact support Supply Kit Expiration Date: ____/____/____

Other concerns or issues to be noted with the AED?

Check list completed by: _____ Date: ____/____/____

(Davidson Schools AED Support Contact: Amanda Walters: 336-242-5552 awalters@davidson.k12.nc.us)

Each academic year, the Bishop McGuinness High School Athletic Training Department's Emergency Action Plan (EAP) is reviewed and rehearsed by the staff athletic trainers. The EAP's are attached here. (Appendix 3) A copy of the EAP is also shared with the WS/Forsyth County EMS and the WS/Forsyth County Director of Emergency Medical Services each year. Additionally, Bishop McGuinness High School Athletics has a Catastrophic Injury Response policy that also includes the EAP steps for a cardiac event as well.

All athletic training staff members are required to be current in CPR/AED for the Professional Rescuer. This certification is also required to maintain BOC certification as an athletic trainer. The CPR/AED for the Professional Rescuer does have as an education component the signs/symptoms of cardiac arrest and does include the following:

Deep gasping can occur within minutes of cardiac arrest and shouldn't be misinterpreted as labored breathing. Eventually, those suffering cardiac arrest will collapse, and roughly half will have involuntary arm and leg movements, which easily can be mistaken for a seizure. When a student-athlete is unresponsive, first responders should call for help and have someone contact emergency medical services; begin chest compressions and CPR; retrieve and use an AED as soon as possible; and clear access for emergency medical personnel.

Automated External Defibrillator Policies and Procedures

Medical Necessity for Use of AED:

Defibrillation is a recognized means of terminating certain potentially fatal arrhythmias during a cardiac arrest. A direct current defibrillator applies a brief, high-energy pulse of electricity to the heart muscle. Automated external defibrillators, or AEDs, were introduced in 1979. AEDs accurately analyze cardiac rhythms and, if appropriate, advise/deliver an electric counter-shock. AEDs are currently widely used by trained emergency personnel and have become an essential link in the "chain of survival" as defined by the American Heart Association:

- Early access
- Early CPR by first responders or bystanders
- Early defibrillation
- Early advanced life support
- Post-hospital cardiac care support

It is recognized that successful resuscitation is related to the length of time between the onset of a heart rhythm that does not circulate blood (ventricular fibrillation, pulseless ventricular tachycardia) and defibrillation. The AHA states with every minute it takes to respond, the chance for successful defibrillation decreases 7-10%. The provision of timely emergency attention saves lives. Athletic events (both practice and competition) present a high risk for cardiopulmonary emergencies. Therefore, by training certified athletic trainers and team physicians in the use of AEDs, the emergency response time is shortened.

Explanation of the Use of AED:

Automated external defibrillator, or AED, means a defibrillator which:

- is capable of cardiac rhythm analysis
- will charge and deliver a counter-shock after electrically detecting the presence of cardiac dysrhythmias
- is capable of continuous recording of the cardiac dysrhythmia at the scene (If available per AED model)

- can produce a hard copy of the electrocardiogram. (If available per AED model)

Defibrillation is only one aspect of the medical care required to resuscitate a patient with a shockable ECG rhythm. Dependent on the situation, other supportive measures may include:

- Cardiopulmonary resuscitation (CPR)
- Administration of supplemental oxygen if available

Medical Protocol Regarding Use of AED:

Use of the AED will follow the American Heart Association AED or American Red Cross treatment algorithm. The AED is to be used only on patients in cardiopulmonary arrest. Before the device is utilized to analyze the patient's ECG rhythm, the patient must be unconscious, pulseless, and not breathing spontaneously

The device is however, not intended for children less than eight years of age and/or victims weighing less than 90 pounds (unless the appropriate pads and shock settings are available)

To Prepare for Defibrillation:

- Verify that the patient is in cardiac arrest (unconscious, no respiration, no pulse).
- Press ON/OFF to turn on the AED. The "connect electrodes message" and voice prompt will occur until the patient is connected to the AED.
- Prepare the patient for electrode placement and plug into the AED as directed.
- Follow the screen messages and voice prompts provided by the AED.
- Press shock button when prompted or continue CPR as indicated

Provisions to Coordinate with Local EMS:

In the event of a cardiopulmonary emergency, the 911 emergency systems should be activated as quickly as possible. The first responders should provide initial care as appropriate to the situation and coordinate with other emergency medical service providers upon their arrival in the provision of CPR, defibrillation, basic life support, and advanced life support.

Operator Considerations:

The Bishop McGuinness High School sports medicine program utilizes the Zoll Plus AED's. The AED is intended for use by personnel (certified athletic trainers, trained/certified coaches, and team physicians)

Personnel using the AED must complete a training session each year, to include instruction in:

- The proper use, maintenance, and periodic inspection of the AED.
- Defibrillator safety precautions to enable the user to administer a shock without jeopardizing the safety of the patient, the user, or other individuals.
- Assessment of an unconscious person to determine if cardiac arrest has occurred and the appropriateness of applying an AED.
- Recognizing that an electrical shock has been delivered to the patient and that the defibrillator is no longer charged.
- Rapid, accurate assessment of the patient's post-shock status to determine if further activation of the AED is necessary

- The operations of the local emergency medical services system, including methods of access to the emergency response system, and interaction with emergency medical services personnel.
- The role of the user and coordination with other emergency medical service provider in the provision of CPR, defibrillation, basic life support, and advanced life support.
- The responsibility of the user to continue care until the arrival of medically qualified personnel.
- Training is documented and kept on-file.

Location of and Maintenance Required for AEDs

The Bishop McGuinness High School sports medicine program has 2 # AED units. They are housed in the athletic training facilities at: BMHS Athletic Training Room

Based upon the sports covered, the AED units may either be maintained in the athletic training facility or carried on-site to the athletic venue. The medical staff will determine the location and use of the AED units at the athletic venues.

Orthopedic Injury Protocol

Initial Evaluation

The primary goals of the initial orthopedic evaluation are to 1) determine whether a true orthopedic emergency is present, 2) begin appropriate treatment, and 3) determine the mode of transport for emergencies or routine extremity trauma.

Visual inspection for deformity and palpation for deformity and point tenderness should be performed, followed by evaluation for gross joint instability. Distal pulse, motor, sensation, and capillary refill (PMSC) should be assessed with any deficiencies and/or changes noted. Clinical tests for suspected long bone fractures such as torque, compression and percussion may be utilized as appropriate by the athletic trainer. For questionable joint instability the use of special tests to identify ligamentous and cartilaginous injury are performed as needed in the assessment process. Application of splints for fracture or gross joint instability is the final step prior to transport. If splints are applied to an extremity injury, PMSC should be evaluated both before and after placement of splints.

Never allow an obvious orthopedic injury to distract from an underlying injury or illness which may be life-threatening.

Orthopedic Emergencies

The increased incidence of bleeding, neurovascular compromise, and treatment complications resulting from infection classify open fractures and/or dislocations as a true orthopedic emergency. Open fractures and dislocations should have a sterile compressive dressing applied as rapidly as possible. As with any open wound, direct pressure should be used to control major bleeding. If direct pressure does not stanch the flow of blood, arterial pressure points should be used. Tourniquets should not be applied to control bleeding. Treatment should then be identical to that of a closed fracture with immediate transport to the closest appropriate emergency facility.

The athletic trainer must also be aware of internal hemorrhage. Occult hemorrhage into the pelvis or femur fracture can account for significant blood loss.

Large joint dislocations (shoulder, elbow, hip, knee, and ankle) constitute an orthopedic emergency. Special attention should be given to knee and elbow dislocations as well as dislocations of the sternoclavicular joint. These most commonly result in neurovascular complications, necessitating emergency management.

Delay in treatment of fractures and dislocations with neurovascular compromise may lead to disastrous consequences including loss of limb and even death. Immediate reduction or realignment by a physician should be performed. If a physician or an emergency facility is not readily available, the athletic trainer may attempt these maneuvers to restore circulation as a part of emergency medical care in a potentially life- or limb-threatening situation. This procedure may be performed by athletic trainers who:

1. Have **verbal orders from the team physician or physician assistant** regarding joint reduction after consulting regarding patient's current signs and symptoms and medical history. If, however, in the clinical opinion of the ATC, the athlete is in a life-or limb-threatening situation and/or significant pain/discomfort that would benefit from joint reduction and a MD verbal order is not immediately available then the ATC may attempt to reduce the dislocation only if knowledgeable/competent in performing the maneuver. If unable to reduce, the athletic trainer should immobilize the joint in the position found, continue to monitor PMSC, and immediate transport to the closest appropriate emergency facility or notify EMS as needed for transport.

Any emergency situations where there is neurovascular compromise should be considered a **"load and go"** situation and emphasis placed on rapid evaluation, treatment, and transportation.

Splinting Guidelines

General rules to follow during the application of a splint include:

- Splinting is useful in emergency situations, for decreased pain, and to allow for easier transport.
- Deformity, gross instability, or crepitus is an indication for immediate splinting, and prompt referral of an unstable joint to an orthopedic surgeon is necessary.
- Assess neurovascular status (PMSC) prior to and after the application of a splint.
- Cover all wounds with sterile compressive dressings prior to the application of a splint.
- Pad the splint to prevent local pressure.
- Immobilization of the joint above and below a fracture or dislocation will decrease movement at the injury site.
- Splinting can be performed in the position of deformity but with experience limb alignment may be helpful
- "When in doubt, splint".

Splinting of Orthopedic Injuries

Splints are used to decrease pain, increase ease of transportation, to prevent closed fracture from becoming open, to minimize damage to nerves, muscles, and blood vessels, and to prevent movement at fracture sites or in the presence of gross instability. The basic rule of splinting is to splint in the position of function. With experience or in the presence of a physician, limb realignment before the application of a splint is acceptable. There are three basic types of splints: 1) rigid, 2) vacuum, and 3) traction. Rigid splints are useful with non-aligned fractures or in the presence of gross instabilities of joints. Vacuum splints consist of a fabric or vinyl splint containing small Styrofoam beads. The splint is placed on the extremity and secured with straps. A pump is attached, and the air is drawn from the splint, compressing the beads together and creating a hard splint conformed to the extremity. Vacuum splints are versatile because of their adaptability to the position of the injured extremity. Traction splints are most frequently used to treat lower extremity femoral fractures. They exert a steady longitudinal pull on the extremity. Traction splints are not suitable for the upper extremity because of potential damage to neurovascular structures in the axilla. Traction splints are routinely found on/carried by EMS personnel.

Procedures for Training in Orthopedic Evaluation and Splinting/Immobilization:

Athletic trainers should review of signs and symptoms of orthopedic injury, evaluation techniques, and splinting/immobilization applications on an annual basis.

NH Secondary School Blood-borne Pathogen Exposure Control Plan

2/1/18 1:00PM

Developed in accordance with the OSHA Blood-borne Pathogens Standard, 29 CFR 1910.1030

Purpose

The purpose of this exposure control plan is to eliminate or minimize employee and student occupational exposure to human blood or other infectious body fluids. Other potentially infectious body fluids include semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, and any bodily fluid visibly contaminated with blood.

[OSHA's Occupational Exposures to Blood-borne Pathogens in Title 29 Code of Federal Regulations 1910.1030 and as revised in 2001 by the Needlestick Safety and Prevention Act P.L. 106-430.]

Scope

This Standard applies to all Novant Health Athletic Training personnel who, during their employment may encounter human blood or potentially infectious body fluids. The term **athletic training personnel** relates to certified athletic trainers who teach and/or perform clinical functions and students performing internships with the Novant Health certified athletic trainers.

Responsibility

Davidson County School System is responsible for providing all necessary supplies such as personal protective equipment, soap, and bleach or disinfecting supplies etc. Most of these supplies are available in the athletic training room or from the Davidson County Physical Plant/Custodial Department. Hepatitis B vaccinations are the responsibility of each certified athletic trainer should he/she desire to have such immunization. The Hepatitis B vaccinations are strongly encouraged. Novant Health requires annual employee training and education regarding exposure control and blood borne-pathogen safety practices. The Davidson County School system is responsible for disposing of bio-hazardous waste contained in biohazard bags or sharps containers. All athletic training personnel are expected to follow policies and procedures of their place of work.

Exposure Determination

OSHA requires employers to perform an exposure determination concerning which employees/personnel may incur occupational exposure to blood or other potentially infectious materials (OPIM). The exposure determination is made without regard to the use of personal protective equipment (i.e., employees are exposed even if they wear personal protective equipment). This exposure determination is required to create a list of job classifications in which **all** employees may be expected to incur occupational exposure, regardless of frequency.

- a. In the athletic training department, the job classifications where **all** employees are considered potentially "At Risk" are found on the list entitled "**List of Job Classification Risk Categorization by Department- All "At Risk."** The job classification and job duties that place these individuals "at risk"

includes the following: *Certified Athletic Trainers employed by Novant Health as employed either academically and/or clinically and students performing internships.*

Task/Procedures:

- Wound Care
- Tactile examination of the skin for wounds and/or dermatoses
- Oral-pharynx examination
- Handling of urine samples
- Cleaning of vomitus
- Assistance to physicians with such activities as suture application, IV application, wound care, joint aspiration and/or injections

Engineering and Work Practice Controls

Universal precautions will be observed by all employees to prevent contact with blood or other potentially infectious materials. All blood or other potentially infectious materials will be considered infectious regardless of the perceived status of the source individual. **All** patients' blood and certain body fluids should be considered infected with HIV, HBV, HCV and/or other blood-borne pathogens, and infection-control precautions adhered to that minimize the risk of exposure to these materials.

Engineering and work practice controls will be utilized to eliminate or minimize exposure and will include:

1. Athletic Training personnel must wash their hands or other skin with soap and water, or flush mucous membranes with water, as soon as possible following an exposure incident (such as a splash of blood to the eyes or an accidental needle stick).
2. Employees must wash their hands immediately (or as soon as feasible) after removal of gloves or other personal protective equipment. **

**Athletic Training personnel shall familiarize themselves with the nearest hand washing facilities for the buildings in which they work. Because most Davidson County High School buildings are public access, they will have available hand washing facilities in public restrooms and custodial / janitorial closets. (If hand washing facilities such as on the practice fields are not available, each athletic training kit will have antiseptic cleansers/hand sanitizers or antiseptic towelettes. If these alternatives are used, then the hands are to be washed with soap and water as soon as feasible.)

3. Athletic training personnel shall properly dispose of any syringes & needles used in the care or treatment of student athletes. Needles shall be disposed of in labeled sharps containers provided at the location.
 - a. Needles should never be recapped.
 - b. Needles may be moved only by using a mechanical device or tool (forceps, pliers, broom, and dustpan).
4. Breaking, sharing, or shearing of needles is prohibited.
5. No eating, drinking, smoking, applying cosmetics or lip balm, or handling contact lenses is allowed in the athletic training where there is a reasonable likelihood of occupational exposure.
6. No food or drinks shall be kept in refrigerators, freezers, shelves, cabinets, or on counter tops or bench tops where blood or other potentially infectious materials are present.
7. Athletic Training personnel must perform all procedures involving blood or other potentially infectious materials in such a manner as to minimize splashing, spraying, splattering, and generation of droplets of these

substances. As a reminder with wound irrigation the use of the “igloo” covers (if available) for syringes is good preventive device for limiting spraying/splashing and splattering.

Housekeeping

Decontamination

Decontamination will be accomplished by utilizing the following materials:

- 10% (minimum) solution of chlorine bleach
 - Whizzer, Clorox products or other EPA registered disinfectants as provided by Davidson County School System.
1. All contaminated work surfaces, tools, objects, etc. will be decontaminated immediately or as soon as feasible after any spill of blood or other potentially infectious materials. The bleach solution or disinfectant must be left in contact with contaminated work surfaces, tools, objects, or potentially infectious materials for at least 10 minutes before cleaning.
 2. Equipment that may become contaminated with blood or other potentially infectious materials will be examined and decontaminated before servicing or use.
 3. Broken glassware will not be picked up directly with the hands. Sweep or brush material into a dustpan.
 4. Known or suspected contaminated sharps shall be discarded immediately or as soon as feasible in containers that is closeable, puncture-resistant, leak-proof on sides and bottom, and marked with an appropriate biohazard label. When containers of contaminated sharps are being moved from the area of use or discovery, the containers shall be closed immediately before removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.
 5. Reusable containers shall not be opened, emptied, or cleaned manually or in any other manner that would expose employees to the risk of percutaneous injury.
 6. The athletic training room facilities must be on a daily cleaning and sanitizing routine. The custodial staff also assists with the cleaning of the facilities as well where available.
 7. See the Housekeeping Appendices per the cleaning and disinfecting athletic training equipment such as coolers, tables etc.

Other Regulated Waste

Other regulated waste shall be placed in containers that are closeable, constructed to contain all contents and prevent leakage of fluids during handling, storage, transportation, or shipping. The waste must be labeled or color coded and closed before removal to prevent spillage or protrusion of contents during handling, storage, or transport.

Biohazard bags and labels are available in Athletic Training Rooms. Athletic training personnel are not to dispose of blood gauze or items with saturated potentially infectious material regarding student-athlete treatment and care into trashcans but to use the bio-hazard containers/bags available in the athletic training room.

Disposal of biohazardous waste bags and sharps containers will be available. This shall be coordinated annually or as needed by the Forsyth County School System. Properly labeled biohazard bags should be given to the custodial staff for disposal as needed. Replacement bags or biohazard labels and ‘spill kit’ materials will be provided by the custodial staff. Sharps containers should be given to the school nurse as he/she will coordinate their disposal.

Currently all biohazard bags and sharps containers in the athletic training facilities are normally red and labeled with the accepted bio-hazard symbol noted below.



Laundry Procedures

Laundry contaminated with blood or other potentially infectious material will be handled as little as possible. Such laundry will not be sorted or rinsed around use. Soiled towels and like laundry are to be washed appropriately at the highest temperature allowed on the washing machine and dried appropriately at the highest temperature allowed on the dryer.

Athletic Training personnel and the involved coaching staff shall coordinate cleaning or disposal of contaminated laundry. The use of disposable latex or vinyl gloves shall be worn with proper handwashing done following completion of the laundry task.

Note that student aides are not permitted to handle bloody or contaminated laundry.

Personal Protective Equipment

Where occupational exposure remains after institution of engineering and work controls, personal protective equipment shall also be utilized.

The Davidson County School System provides gloves, face shields, eye protection, commercial spill clean-up kits and aprons to athletic training personnel for use in blood borne pathogen protection.

All personal protective equipment will be chosen based on the anticipated exposure to blood or other potentially infectious materials. The protective equipment will be considered appropriate only if it does not permit blood or other potentially infectious materials to pass through or reach the employee's clothing, skin, eyes, mouth, or mucous membranes under normal conditions of use and for the duration of time for which the protective equipment will be used.

Athletic Training personnel must:

- Utilize protective equipment in occupational exposure situations.
- Remove garments that become penetrated by blood or other potentially infectious material immediately or as soon as feasible.
- Replace all garments that are torn or punctured, or that lose their ability to function as a barrier to blood-borne pathogens.
- Remove all personal protective equipment before leaving the work area.
- Place all garments in the appropriate designated area or container for storage, cleaning, decontamination, or disposal.

Gloves

Glove use is required for the following and should be adhered to:

- A. Wound Care
- B. Tactile examination of the skin for wounds or dermatoses
- C. Oral-pharynx Examination
- D. Handling of Urine Samples, throat cultures, etc.
- E. Assistance to physicians in the following procedures:
 - 1. Suture application
 - 2. IV application
 - 3. Debridement of wounds
 - 4. Aspiration of joints
 - 5. Injections

Bio-hazardous Spill Procedures

Biohazard Spill

1. Keep others out of the area to prevent spreading spilled material. Post warning signs if needed.
2. Contaminated clothing should be removed and placed in a biohazard bag for disinfecting/decontamination.
3. Wash hands and any exposed skin.
4. Put on protective clothing (gown, gloves, face protection and shoe covers, depending on the amount of spilled material).
5. Pick up any broken glass with forceps and dispose in a Sharps container.
6. Cover the spill with paper towels and add 10% bleach or use commercial spill clean-up kit.
7. Allow 20 minutes contact time, discarding used paper towels in biohazard bag.
8. Re-wipe the spill area with disinfectant.
9. Place all contaminated materials into a biohazard waste container, including gloves.
10. Wash hands with soap and water.

HEPATITIS B

A. The Hepatitis B vaccine is offered to all Novant Health employees free of charge. All unvaccinated Category I and Category II employees (as defined by OSHA Regulations) or Category I as defined by the hospital Exposure Control Plan are counseled and strongly encouraged to take the Hepatitis B Vaccine within 10 days of job assignment. After initial vaccine, an appointment for the second will be given one month later, and then the third vaccine will be given five months after the second vaccine. All new employee applicants are given a copy of the Informed

Consent Form for the Hepatitis B Vaccine.

B. The Infection Prevention Department and other designated departments will provide education on Standard (Universal) Precautions.

C. Health Care Personnel (HCP) will be tested for HBsAb, 1-2 months after completing the vaccination series to determine serologic response.

D. Personnel who do not respond to the primary vaccination series will be revaccinated with a second three-dose vaccine series.

POLICY/PROCEDURE Healthcare Worker Immunizations/Vaccinations Administration

The electronic version of this document is the current approved version; therefore, printed copies are uncontrolled documents and may not be accurate. Before using a printed copy, verify that it is the current version in Novant Health Document Manager.

E. Re-vaccinated persons should be tested for HBsAb at the completion of the second vaccine series. If they do not respond, no further vaccination series should be given. EOH will evaluate the employee for the presence of Acute Hepatitis B panel including HBsAg and HBeAg to check for remote or active disease.

F. Routine booster doses of the vaccine are not recommended because persons who respond to the initial vaccine series remain protected against clinical hepatitis and chronic infection even when their HBsAb levels become low or undetectable.

G. The hepatitis B vaccine will be offered again to all unvaccinated employees or those without proven immunity by titer who have had a bloodborne pathogen exposure, excluding vaccine non-responders who have received a total of 6 doses of vaccine.

H. Contraindications:

1. A history of a serious reaction (e.g., anaphylaxis) after a previous dose of hepatitis B vaccine or to a hepatitis B vaccine component

I. Healthcare Personnel Vaccination Recommendation

1. Give 3-dose series (dose #1 now, #2 in one month, #3 approximately 5 months after #2).
2. Give IM.
3. Obtain HBsAb serologic testing 1-2 months after dose #3.

Hepatitis B Virus vaccine consent/declination form

Employee Name: _____

Employee ID Number: _____ Place of Employment: _____

The hepatitis B vaccine currently used is a noninfectious subunit viral vaccine derived from hepatitis B surface antigen (HBsAg) produced by a recombinant strain of the yeast *Saccharomyces cerevisiae*. When injected into the deltoid muscle, the hepatitis vaccine induced protective levels of antibodies in more than 90 percent of healthy individuals who received the recommended three doses of the vaccine. Persons with immune-system abnormalities, such as dialysis patients, have less response to the vaccine, but over half of those receiving it do develop antibodies. Full immunization requires three doses of vaccine over a six-month period (although some persons may not develop immunity even after three doses). There is no evidence that the vaccine has ever caused hepatitis B. However, persons who have been infected with hepatitis B virus prior to receiving the vaccine may go on to develop clinical hepatitis despite immunization. The duration of immunity is unknown currently.

The incidence of side effects is low. Serious side effects do not appear to be common but have been identified on rare occasions. Some persons experience tenderness and redness at the site of the injection. Low grade fever may occur. Rash, upper respiratory symptoms, nausea, joint pain, and mild fatigue are among reported side effects. More serious side effects may be identified in the future after more extensive use of the vaccine.

If I am known to be pregnant or breast feeding, I understand that I should consult with my attending physician and report to employee occupational health in the next 10 days regarding my decision or decline vaccination at the present time.

Hepatitis B vaccine consent

I, hereby authorize my employer to administer to me the hepatitis B vaccine. All my questions have been answered to my satisfaction, and I agree to accept the hepatitis B vaccine, given in three doses to be given during a six months' time.

Signature: _____ Date: _____

Witness: _____ Date: _____

Hepatitis B vaccine declination

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination currently. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future, I continue to have occupational exposure to blood, or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Signature: _____ Date: _____

Witness: _____ Date: _____

Check if applies to you

- ☐ I have completed my hepatitis B series. I will (have) provide{d} the company with documentation (if attainable).
- ☐ I do not work in a job category that results in predictable or unpredictable exposure to blood/body fluids at this time, but understand that I may schedule an appointment if I would like to discuss personal non-work-related reasons for vaccination. If I change to a job that results in potential exposure, I will report to the employee occupational health office for vaccination if desired.

Post Exposure Evaluation and Follow-up

All exposure incidents shall be reported, investigated, and documented. When the employee incurs an exposure incident, it shall be reported immediately to their supervisor. All exposure incidents involving the use of sharps (or any percutaneous procedure) shall be recorded in the Sharps Injury Log, which will be kept for a minimum of five years.

If an employee has an occupational exposure incident must complete the NH and Bishop McGuinness High School Pathogen Incident Report and the following protocol or steps should be followed:

1. Immediately wash the wound and the skin that have been in contact with blood or bodily fluids with soap and water; for mucous membrane, splashes to nose, mouth, or skin exposures, flush with copious amounts of water. Irrigate eyes with clean water, saline, or sterile wash.
2. Seek medical treatment as soon as possible after the incident. Immediately contact your supervisor and seek medical attention as soon as possible or within 2 – 4 hours of the incident exposure at the Emergency Department/Urgent or with your own physician. Inform the intake personnel that you have had a blood-borne pathogen exposure.
3. Notify your supervisor or Bishop McGuinness High School
4. The athletic personnel must complete all sections of the incident report and submit to the (NH and WS/FCS) within 24 hours of the incident to ensure that you receive appropriate follow up care.
5. If the employee refuses to seek treatment or to consult with his/her, have the employee check the appropriate box and sign with a witness (I, of my own free will and volition, have elected not to have a medical evaluation) on part III of the Exposure Incident Reporting form.

Following a report of an exposure incident, the exposed athletic training personnel shall go to the local emergency room/urgent care facility or PCP for a confidential medical evaluation and follow-up, including at least the following elements:

1. Documentation of the route(s) of exposure
2. A description of the circumstances under which the exposure occurred. If the exposure involved the use of sharps (or any percutaneous procedure), this description must include the following:
 - A. The type and brand of the device involved in the incident.
 - B. The department or work area where the exposure occurred.
 - C. An explanation of how the incident occurred.
3. The identification and documentation of the source individual (The identification is not required if the athletic training personnel can establish that identification is impossible or prohibited by state or local law.)
4. The collection and testing of the source individual's blood for HBV and HIV serological status
5. Post-exposure treatment for the individual, when medically indicated in accordance with the U.S. Public Health Service
6. Counseling
7. Evaluation of any reported illness

Documentation of the above as permitted must be kept on-file in the NH HR office.

The Healthcare professional evaluating the involved party will be provided with the following information:

1. A copy of this plan.
2. A copy of the OSHA Blood-borne Pathogen regulations (29 CFR 1910.1030)
3. Documentation of the route(s) of exposure.
4. A description of the circumstances under which the exposure occurred.
5. Results of the source individual's blood testing, if available.
6. All medical records applicable to treatment of the employee, including vaccination status.

The involved individual will receive a copy of the evaluating healthcare professional's written opinion within 15 days of the completion of the evaluation.

Documentation of the above as permitted must be kept on-file in the NH HR Office.

The healthcare professional's written opinion for Hepatitis B vaccination is limited to the following: (1) whether the individual needs Hepatitis B vaccination; (2) whether the individual has received such a vaccination. The healthcare professional's written opinion for post-exposure evaluation and follow-up is limited to the following information:

1. That the individual was informed of the results of the evaluation.
2. That the individual was informed about any medical conditions resulting from exposure to blood or other infectious materials that require further evaluation or treatment.

All other findings or diagnoses will remain confidential and will not be in a written report. Documentation of the above as permitted must be kept on-file in the Head Athletic Trainer's Office. No release of athletic training personnel regarding exposure will be released as permitted by law without the individual's written consent.

All medical evaluations shall be made by or under the supervision of a licensed physician or by or under the supervision of another licensed healthcare professional. All laboratory tests must be conducted by an accredited laboratory at no cost to the employee. All medical records will be kept in accordance with 29 CFR 1910.1020.

Training

All high-risk athletic training personnel shall participate annually in the Novant Health training program and is free of charge to the participants. Additional training will be provided when changes such as modification of tasks or procedures affect the employee's occupational exposure.

Any athletic training personnel who are exposed to infectious materials shall receive training, even if the employee was allowed to receive the HBV vaccine after exposure.

The training program will include at least the following elements:

1. An accessible copy of the regulatory text of 29 CFR 1910.1030 and an explanation of its contents.
2. A general explanation of the epidemiology and symptoms of blood-borne diseases.
3. An explanation of the modes of transmission of blood-borne pathogens.
4. An explanation and copy exposure control plan
5. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood or other potentially infectious materials.
6. An explanation of the use and limitations of methods that will prevent or reduce exposure, including appropriate engineering controls, work practices, and personal protective equipment.

7. Information on the types, proper use, location, removal, handling, decontamination, and disposal of personal protective equipment.
8. An explanation of the basis for selection of personal protective equipment.

Training will be by viewing a computer based learning presentation and then taking a quiz following. Athletic Training personnel must pass with 80% or better grade.

A copy of all those who have completed the annual blood borne pathogen training and the date of such training shall be kept on-file with Novant Health Human Resources.

IMPORTANT NOTE:

In various encounters among students and student athletes, they may need to be considered both as sources and as parties at risk for blood-borne pathogen exposure, particularly those involving bloody injuries, lacerations, or puncture wounds. Some examples are:

- a. Fights
- b. Biting incidents
- c. Contact-sport athletic injuries
- d. Accidental, traumatic events with multiple victims (e.g., hallway collisions, parking lot motor vehicle collisions, site structure failures)
- e. Events in which one student comes to the aid of another injured student

ADDITIONAL NOTES:

All workout/exercise equipment and therapy equipment must be cleaned or sprayed after each person's use with an approved germicidal cleanser. Water coolers and squirt bottles will be cleaned and disinfected after each session of use and stored appropriately. This can be done with soap and water or commercial sanitizers/disinfectants.

Sport playing rules require that a player be removed from competition when there is presence of bleeding or a weeping open wound. The wound must be covered and treated as needed prior to the athlete's return to play. This will also hold true for non-competition activity. Should the uniform/practice gear become blood soaked it must be changed. Should the uniform/practice gear have some "splattering" of blood upon it, the area must be disinfected and/or covered/protected prior to returning to athletic activity

All open wounds or sores or questionable pimples/spider bits or infected hair follicles per dermatoses should be treated as potential MRSA (Methicillin-Resistant Staphylococcus Aureus). These types of conditions should be cleansed with soap and water or commercial cleanser such as Hibiclens and be covered and protected. Any signs of infection should warrant physician examination or referral as needed.

Resource: **OSHA Blood-borne Pathogens Standard, 29 CFR 1910.1030**

www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=10051&p_table=STANDARDS

NH SECONDARY SCHOOL ATHLETIC TRAINING

BLOOD-BORNE PATHOGEN EXPOSURE INCIDENT REPORT

may also use Davidson County Form at: Bishop McGuinness High School

**** This must be submitted to the Athletic Trainer within 24 hours of incident!**

CONFIDENTIAL

Part I • General Information

Name of Exposed Athletic Training Personnel: _____

Date of Birth: ____/____/____ Local/Cell Phone #: () _____

Local or Current Address: _____

City

State

Zip

Part II • Description of Incident

Date and Time of Incident: ____/____/____ Time: _____ AM PM (circle)

Location of Incident: _____

Body Part Affected: _____

Route of Exposure (puncture, needle stick, splash, etc.): _____

Description of the incident: _____

Names of witness and contact information for them: _____

Exposed Individual Signature: _____ Date: ____/____/____

Supervisor Signature: _____ Date: ____/____/____

Does this Exposure Incident Require a Source Information and Consent Form: () YES () NO

Part III • Post-Exposure and Follow-Up Examination

I, _____, am part of the Novant Health athletic training personnel at _____.

On _____ (date), I was involved in an exposure incident defined by OSHA.

A copy of the Incident Report is attached, and I further understand that the purpose of post-exposure is to assure my full understanding of whether I have been exposed to or been infected with an infectious disease because of this incident.

I have elected to have the medical evaluation. I understand it is my responsibility to seek this medical attention as soon as possible, within 2 –4 hours. I will seek emergency medical care from:

A. ☐ My own personal physician:

Name of Physician: _____

Address: _____

Telephone Number: () _____

B. ☐ Emergency Department/Urgent Care Center (please specify): _____

C. ☐ Other: _____

D. ☐ I, of my own free will and volition, have elected not to have a medical evaluation (must be signed by a witness)

Your Printed Name: _____

Your Signature: _____ Date: ____/____/____

Street Address: _____

City State Zip:

Witness Printed Name: _____

Witness Signature: _____ Date: ____/____/____

**For those individuals that seek medical attention for an exposure incident must present documentation to have on-file for such care received and any follow-up care and/or limitations required by the attending health care provider/facility. Additionally, documentation must be presented that permits the individual to return to athletic training duties from the attending health care provider/facility. Failure to produce the required documentation will prohibit the individual to return to the athletic training department/athletic training duties until such time it is received.*

SPECIFIC HOUSEKEEPING APPENDICES

A. Taping/Treatment Tables, Treatment & Rehabilitation Equipment, Countertops, Stools etc.

These need to be cleaned every day and/or following a possible contamination using isopropyl alcohol or other approved commercial disinfectant/germicidal cleaner. (1:10 diluted bleach solution can be used to clean hard surfaces only!) Apply solution to surface and allowed to sit for 2 minutes than wipe down with a towel.

B. Coolers and Ice Chests:

Coolers and ice chest must be cleaned and dried and stored properly each day after use. Choices for cleaning include Clorox Anywhere alcohol, hot soapy water or other approved commercial disinfectants and germicidal cleansers. Make note to clean the spigots and lids as well.

C. Water Bottles, Water Bottle Lids and Carriers:

Water bottles, lids and carriers should be cleaned and disinfected every day following use. Choices for cleaning include Clorox Anywhere alcohol, hot soapy water or other approved commercial disinfectants and germicidal cleansers.

D. Pillowcases, Hot Pack Covers, Soft Goods:

Pillowcases should be laundered every day and in the event of contamination the pillowcase should be removed and placed in the next laundry load. The underlying pillow should also be cleaned using Clorox Anywhere, alcohol, or other approved commercial disinfectants and germicidal cleanser. Hot pack should be treated the same as pillowcases and placed in the laundry. Soft goods such as neoprene sleeves, ankle braces etc. should be laundered upon return to the athletic training room. Items that cannot be laundered (ex. Air cast, hard splints etc.) should be disinfected with guidelines for tables and rehabilitation equipment.

E. Storage and Handling of Ice:

Ice for water coolers must be manufactured from an approved water supply. The ice should be transferred or dispensed with a scoop, spoon, or sanitary method. When not in use the scoop maybe stored on a clean surface but not in water.

F. Whirlpools:

Whirlpools must be cleaned daily or as needed following contamination. Whirlpools may not be used by athletes with open or draining wounds. Cleaning choices include using isopropyl alcohol or approved commercial disinfectant/germicidal cleaner. (1:10 diluted bleach solution can also be used) Apply solution to surface and allowed to sit for 2 minutes than wipe down with a towel or rinse with HOT water and then wipe down with towel or let air dry. The whirlpool turbine can also be cleaned by allowing the cleaning solution mixed with hot water to circulate through the running turbine for 10 minutes.

***** Athletic staff or student-athletes who have exulted lesions or weeping dermatitis on their hands should refrain from direct contact with athletes, laundry, and refrain from the handling of patientcare or devices used in performing invasive procedures until the condition resolves. *****

****DO NOT use Bleach and Ammonia at the same time as HARMFUL & HAZARDOUS FUMES will occur!***

QUICK TIPS-REMINDERS

INTRODUCTION:

Due to the recent attention being given to such infectious diseases as HIV, Hepatitis B and Methicillin-Resistant Staphylococcus Aureus (MRSA), it is in the best interest of the athletic staff and students to adopt safe and consistent precautions when dealing with blood-borne pathogen issues. Blood-borne pathogens can be transmitted from person to person and/or surface contact to person via blood, body fluids, mucous membranes, and skin abrasions.

The following policies are to be instituted and used. Those individuals who fail to comply with the following universal precautions and cleaning procedures are placing themselves and others at risk for infection.

Note: Individual(s) responsible for cleaning and disinfecting equipment or areas must always adhere to Universal Precautions and wear personal protection equipment as needed.

GENERAL UNIVERSAL PRECAUTIONS STATEMENTS/PROCEDURES:

1. Hands shall be washed before and after contact with athletes. Hands shall be washed even when gloves are being used. If hands encounter blood, body fluids, and/or human tissue, they should be washed immediately. Acceptable washing includes soap and water or an antimicrobial cleanser.
2. Athletic staff or student-athletes who have excoriated lesions or weeping dermatitis on their hands should refrain from direct contact with athletes, laundry, and refrain from the handling of patient care or devices used in performing invasive procedures until the condition resolves.
3. Gloves shall be worn when contact with blood, body fluids, tissue, contaminated surfaces, and soiled clothing is anticipated. This needs to be done when treating open wounds, laundering towels, uniforms, and practice gear. Bloody gauze pads, dressings, and Band-Aids, etc. are to be placed in a biohazard container. This also includes disposable thermometer covers. In case of spurting wounds etc. there are personal protection packs with gowns and mask available in the athletic training rooms.
4. To minimize the need for emergency care mouth-to-mouth resuscitation, pocket masks are accessible in each team's athletic training kit or available in the athletic training room.
5. Sharp objects shall be handled in such a manner as to prevent accidental cuts or punctures. Used scalpel blades and needles should not be bent, broken, or bimanually inserted into their original sheath or unnecessarily handled. They should be discarded intact immediately after use into an impervious sharp's disposal box located in the athletic training room.
6. If a blood or body fluid spill occurs, it should be cleaned up promptly. Soak blood or fluid spill with germicide or approved "spill clean-up kit", wiped up with gloved hands and then apply new germicide to the area to be wiped up for a second time. Recommended use for blood spill is a 1:10 dilution of bleach or tuberculocidal/commercial germicidal/antimicrobial solution.
7. All athlete specimens of body fluids, i.e., urine, shall be transported in a container that prevents leaking. The preferred choice is the commercially approved drug testing kits.
8. All athletes and staff must shower after physical activity and before entering the athletic training rooms to seek care and treatment for injury or illness.
9. All workout/exercise equipment and therapy equipment must be cleaned or sprayed after each person's use with an approved germicidal cleanser. Water coolers and squirt bottles will be cleaned and disinfected after each session of use and stored appropriately.

10. Playing rules require that a player be removed from competition when there is presence of bleeding or a weeping open wound. The wound must be covered and treated as needed prior to the athlete's return to play. This will also hold true for non-competition activity. Should the uniform/practice gear become blood soaked it must be changed. Should the uniform/practice gear have some "splattering" of blood upon it, the area must be disinfected and/or covered/protected prior to returning to athletic activity.

11. Blood stained/soaked uniforms or practice gear, towels, etc. or those exposed to bodily fluids should be washed separately from those that are not contaminated. They should also be transported separately from the non-contaminated laundry. The individual(s) charged with laundry duties should wear protective gloves or clothing as needed. While handling the laundry, no food, open drink containers, no cosmetics or lip balm should be applied, no handling of contact lens or eye wear should be touched nor in the vicinity. Laundering with hot water is recommended per the laundry for germ killing purposes along with drying at high temperatures.

12. Eating, drinking, food or open drink containers, no cosmetics or lip balm should be applied; no handling contact lens or eye wear should be permitted in the work areas as there is likelihood of occupational exposure to blood or other potentially infectious materials. Athletes must be discouraged from sharing shaving utensils, towels, drinking cups and eating utensils. Showering after all athletic activity is a MUST for hygiene purposes. Fluids from squirt bottles must be squirted into the mouth with lips-teeth and tongue NEVER touching the spouts.

13. Water coolers, ice chest and water bottles must be cleaned and dried after use each day and stored properly. Water coolers and ice chest can be cleaned with hot water and commercial disinfectants as available.

Epi-Pen Policies and Procedures

Revised 2/1/18

Epinephrine Auto-Injector Introduction

Epinephrine is the drug of choice for the emergency treatment of severe allergic reactions to insect stings or bites, foods, drugs, or other allergens and for basic life support treatment for severe asthma. Epinephrine mimics the responses of the sympathetic nervous system. It quickly constricts blood vessels to improve blood pressure, reduces the leakage from the blood vessels, relaxes smooth muscle in the bronchioles to improve breathing through bronchodilation and alleviate the wheezing and dyspnea, stimulates the heartbeat, and works to reverse the swelling and hives. *The drug takes effect within seconds, but the duration of its effectiveness is short (about 10-20 minutes).*

The Novant Health athletic training staff utilizes the Epi-Pen Auto-Injector, a disposable delivery system for self-administration. The Epi-Pen has a spring activated needle that is designed to deliver a single precise dose (0.3 mg of 1:1000 solution) of epinephrine to adults when activated. The Epi-Pen Jr. has a spring activated needle that is designed to deliver a single precise dose (0.15 mg. of 1:1000 solutions) of epinephrine to infants/children under 8 years old when activated. It may be necessary in very severe reactions to administer a second dose after five minutes if initial response is inadequate.

Emergency Care for Anaphylaxis and/or Severe Asthma with Epi-Pen

The sports medicine staff should:

- call for EMS (if not on-site or in-route)
- maintain a patent airway
- suction any secretions if suction device available
- administer oxygen therapy at 15 liters/minute with non-rebreather device if available
- be prepared to assist ventilation manually or with positive pressure ventilation with bag-valve-mask if available
- administer epinephrine by a prescribed auto-injector
- initiate early emergency transport

Indications/Contraindications for Epinephrine Administration

Epinephrine should be administered if the patient exhibits signs and symptoms of a severe allergic reaction (anaphylaxis), including respiratory distress and/or shock (hypoperfusion) or severe asthma. Patients who have progressed to severe asthma experience a combination of the following: shortness of breath (>30 respirations/min.), mental status changes (anxious, confused, combative, and drowsy), inability to speak in sentences, sweaty and unable to lie down. There are no contraindications for the administration of epinephrine in a life-threatening allergic reaction or severe asthma; however, precautions should be taken with elderly patients or patients with heart disease or hypertension.

Administration of Epinephrine

- Check the Epi-Pen to ensure the medication has not expired, has not become discolored, and does not contain particulates or sediments.
- Prep skin site with alcohol
- Remove the gray safety cap from the auto-injector
- Place the tip of the auto-injector against the lateral aspect of the patient's thigh midway between the waist and knee
- Push the injector firmly against the thigh until the spring-loaded needle is deployed and the medication is injected (at least 10 seconds)
- Dispose of the auto-injector in a biohazard container designed for sharp objects. Be careful not to prick yourself since the needle will now be protruding from the end of the injector
- Record that epinephrine was administered, the dose, and the time of administration

Side Effects

The patient may complain of side effects following the administration of epinephrine. Possible side effects include increased heart rate, pale skin (pallor), dizziness, chest pain, headache, nausea, vomiting, excitability, and anxiousness.

Reassessment

Following the administration of epinephrine, it is necessary to reassess the patient. Reassessment should include continued evaluation of airway, breathing and circulatory status. Decreasing mental status, decreasing blood pressure, and increasing difficulty in breathing indicate the allergic reaction or severe asthma is worsening. If the condition is worsening, consider the following interventions: injection of second dose of epinephrine if second auto-injector is available, provide emergency care for shock, be prepared to administer positive pressure ventilation with supplemental oxygen if breathing becomes inadequate (if equipment is available), and be prepared to initiate CPR and apply AED if patient becomes pulseless.

If the patient's condition improves following administration of epinephrine, continue to perform ongoing assessments. Be aware patient may complain of side effects from the epinephrine. Conscious patients may also be administered a 50 mg. diphenhydramine tablet orally or sublingually for antihistamine effects (if permitted). Continue oxygen therapy with a non-rebreather device (if available) and treat for shock if necessary. *Any patient requiring epinephrine administration should be transported to the closest available medical facility for follow-up evaluation and treatment as soon as possible. Remember that epinephrine is short-acting (10-20 minutes), and signs and symptoms may return as drug wears off.*

Procedures for Training and Testing in Use of Epi-Pen Auto-Injector

Personnel should complete a training session each year with review of signs and symptoms and emergency medical care for allergic reaction, anaphylaxis, anaphylactic shock, and severe asthma. Personnel should complete a training session each year with instruction in the proper use and maintenance of the Epi-Pen and practice with the Epi-Pen Trainer.

Asthma Medication Metered Dose Inhaler (MDI) Policies and Procedures

Asthma Introduction

Although the exact causes of asthma are unknown, several factors, including exercise, may induce an asthma attack. Many patients with asthma and patients with allergies will have exercise-induced bronchospasm (EIB). EIB usually occurs during or minutes after vigorous activity, reaches its peak 5-10 minutes after stopping the activity, and usually resolves in another 20-30 minutes.

Asthma Medications

Depending on the severity of asthma, medications can be taken on an as-needed basis (prn) or regularly to prevent or decrease breathing difficulty. Most of the medications fall into two major groups: quick relief medications and long-term control medications.

Quick relief medications are used to treat asthma symptoms or an asthma episode. The most common quick relief medications are the short-acting beta-agonists that relieve asthma symptoms by relaxing the smooth muscles around the airways. Common beta-agonists include Proventil and Ventolin (albuterol), Maxair (pirbuterol), and Alupent (metaproterenol). Atrovent (ipatroprium), an anticholinergic, is a quick relief medication that opens the airways by blocking reflexes through nerves that control the smooth muscle around the airways. Steroid pills and syrups, such as Deltasone (prednisone), Medrol (methylprednisolone), and Prelone or Pediapred (prednisolone) are very effective at reducing swelling and mucus production in the airways; however, these medications take 48-72 hours to take effect.

Long-term control medications are used daily to maintain control of asthma and prevent asthma symptoms. Intal (cromolyn sodium) and Tilade (nedocromil) are long-term control medications which help prevent swelling in the airways. Inhaled steroids are also long-term control medications. In addition to preventing swelling, they also reduce swelling inside the airways and may decrease mucus production. Common inhaled steroids include Vanceril, Vanceril DS, Beclovent, and Beclovent DS (beclomethasone), Azmacort (triamcinolone), Aerobid (flunisolide), Flovent (fluticasone) and Pulmicort (budesonide). Leukotriene modifiers are new long-term control medications. They may reduce swelling inside the airways and relax smooth muscles around the airways. Common leukotriene modifiers include Accolate (zafirlukast), Zyflo (zileuton) and Singulair (montelukast). Another long-term control medication, Theophylline, relaxes the smooth muscle around the airways. Common theophylline in oral form includes Theo-Dur, Slo-Bid, Uniphyll and UniDur. Serevent (salmeterol), in inhaler form, is also a long-term control medication. As a long-acting beta-agonist, it opens the airways in the lungs by relaxing smooth muscle around the airways. Advair is another long-term inhaled medication that has a broncho-dilator and steroid component to it.

Inhaled Medications

Inhaled medications are delivered directly to the airways, which is useful for lung disease. Aerosol devices for inhaled medications may include the metered-dose inhaler (MDI), MDI with spacer, breath activated MDI, dry powder inhaler or nebulizer. The most used inhaled medications are delivered by the MDI, with or without the spacer. There are few side-effects because the medicine goes right to the lungs and not to other parts of the body.

It is critical that the patient use the prescribed MDI correctly to get the full dosage and benefit from the medication. Unless the inhaler is used in the right manner much of the medicine may end up on the patient's tongue, the back of their throat, or in the air. Use of a spacer or holding chamber helps significantly with this problem and their use is strongly recommended. A spacer is a device that attaches to an MDI and holds the medication in its chamber long enough for the patient to inhale it in one or two slow deep breaths. This eliminates the possibility of inadequate medicine delivery from poor patient technique.

Using the MDI

The Novant Health sports medicine staff may assist a student-athlete in the use of a prescribed MDI as follows:

- Remove the cap from MDI and hold the inhaler upright
- Shake the inhaler
- Tilt patient head back slightly and have patient breathe out
- Open mouth with inhaler 1-2 inches away (or mouth to spacer mouthpiece if spacer available)
- Press down on the inhaler to release the medication as patient starts to breathe in slowly
- Patient breathes in slowly for 3-5 seconds
- Patient holds breath for 10 seconds to allow the medication to reach deeply into the lungs
- Repeat puffs as prescribed; waiting 1 minute between puffs may permit the 2nd puff to go deeper into the lungs

If possible, auscultate breath sounds and measure peak expiratory flow rate (PEFR) prior to and after MDI administration if the equipment is available.

Basic Life Support Treatment for Severe Asthma

Patients who have progressed to severe asthma experience a combination of the following: shortness of breath (>30 respirations/min.), mental status changes (anxious, confused, combative, drowsy), inability to speak in sentences, sweaty and unable to lie down. If the patient is not responding to or is unable to properly use their MDI, the sports medicine staff should:

- call for EMS (if not on-site or in-route)
- maintain a patent airway
- suction any secretions (if equipment is available)
- administer oxygen therapy at 15 liters/minute with non-rebreather device (if equipment is available)
- be prepared to assist ventilation with positive pressure ventilation with bag-valve-mask (if equipment is available)
- administer epinephrine by a prescribed auto-injector if permitted (refer to Epi-Pen Policies and Procedures)
- initiate early emergency transport

Assisting the administration of albuterol or sterile saline by nebulizer if provided by the athlete is also permitted with athletes having a history of reactive airway or EIA associated with shortness of breath, wheezing and/or chest tightness. This therapy may be given 6 times as needed and if no improvement with treatment, then physician referral is indicated.

Procedures for Training and Testing in Use of MDI

Personnel must complete a training session each year with review of signs and symptoms of asthma and instruction in the proper use of the nebulizer and MDI with and without spacer.

Return to Sports Activity After Infectious Mononucleosis Protocol

(get Dr. Sandbulte to approve)

Background

- Peak incidence is between ages 15-19
- 1-3% of college students infected per school year
- Incubation period 30-50 days
- No controlled trials on when to return to play due to ethics
- Most reports site, it takes 4 weeks for lymphocytosis and for liver chemistry to return to normal

Splenomegaly

- Caused by an increased lymphatic infiltration affecting the support structures in the spleen resulting in a distorted and fragile spleen. No reports delineate how long these changes continue.
- Further studies have shown that splenic enlargement was noted by ultrasound, but of those, only 17% had palpable spleens.
- 50% of those with IM have splenomegaly. Some studies say 100%. Spleens may be enlarged 2-3 times normal size.
- Unfortunately, spleen size on ultrasound varies greatly. According to the AMSSM position statement on MONO: One-time imaging of the spleen for assessment of splenomegaly at the time of illness is not recommended because of the wide variability encountered in normal values. Ultrasound should only be used if clinically indicated.

Splenic Rupture

- It is estimated that splenic rupture occurs in 0.1-0.5% of all cases of IM.
- Figures show that the risk of splenic rupture is highest in the second and third week of illness during which time there is maximal increase in spleen size.
- Almost all cases occur between 4-21 days of illness. Rupture after 1 month is less common.

Return to Sports Activity Recommendation

- No contact sports or strenuous activity (weightlifting) for minimum of 3 weeks/21 days after onset of illness or for a minimum of 3 weeks/21 days after diagnosis if onset is not known.
- After week 3 or 21 days: If the patient is afebrile, has normal lab, is well hydrated and asymptomatic (including no fatigue) then light exercise at 50% pre-illness aerobic conditioning is allowed. No exercises where Valsalva required (i.e., weightlifting). No contact activities allowed.
- After week 4 or 28 days: If the patient tolerated step one (aerobic activity) for one week without relapse of symptoms, then he/she can be considered for clearance to return progressively to normal activity after evaluation by the team physician (must be more than 4 weeks/28 days from onset of symptoms).

Electrical Safety Tips

U.S. fire departments responded to an estimated annual average of 47,820 reported home structure fires involving electrical failure or malfunction in 2007-2011. These fires resulted in 455 civilian deaths, 1,518 civilian injuries and \$1.5 billion in direct property damage.

- Replace or repair damaged or loose electrical cords.
- Avoid running extension cords across doorways or under carpets.
- Consider having additional circuits or outlets added by a qualified electrician so you do not have to use extension cords.
- Follow the manufacturer's instructions for plugging an appliance into a receptacle outlet.
- Avoid overloading outlets. Plug only one high-wattage appliance into each receptacle outlet at a time.
- If outlets or switches feel warm, frequent problems with blowing fuses or tripping circuits, or flickering or dimming lights, call a qualified electrician.
- Place lamps on level surfaces, away from things that can burn and use bulbs that match the lamp's recommended wattage.
- Make sure healthcare clinic has ground fault circuit interrupters (GFCIs) in whirlpool and wet areas and outdoor areas. (GFCIs are recommended in all healthcare facility outlets)
- Periodically inspect all electrical equipment and cords to ensure proper use and safe conditions. Improper use of electrical devices to obtain more outlet capacity can result in overloaded circuits and fire.
- The use of extension cords should be minimal and used only when a flexible, temporary connection is necessary. The cord and the outlet should be checked periodically to ensure overheating is not occurring. Extension cords cannot be used for fixed wiring and should never be tacked, stapled, tied, hidden under rugs, or draped over pipes or other supports, fastened to or through woodwork, ceilings, or walls. When there is a permanent need of an electrical outlet, one should be installed.
- Be sure all electrical equipment is properly grounded. If any evidence is found of frayed, cracked, or damaged wiring or electrical outlets, the equipment should be taken out of service until repairs are made.
- Have all electrical outlets inspected at least annually and keep a record of such inspections.

Suspected Spinal Injury 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. C-spine in-line stabilization should be maintained.
- The athlete's airway, breathing, circulation, level of consciousness and neurological status should be assessed. If airway is impaired, maintain c-spine in-line stabilization simultaneously with airway using a modified jaw thrust maneuver. If the athlete breathing is inadequate, assist, if possible, with ventilations from a bag-valve-mask (if available), the use an airway insertion device if needed (if available) and provide supplemental oxygen as well if needed (if available).
- EMS should be activated.
- The athlete should not be moved until immobilized unless essential to maintain airway, breathing and circulation. If the athlete must be moved, the athlete should be placed in a supine position while maintaining spinal immobilization.
- In a situation where it may not be appropriate for on-site medical personnel to transfer the athlete to a long spine board prior to EMS arrival (lack of enough qualified help or other factors), the rescuer(s) should maintain in-line stabilization, place a rigid cervical collar on (if possible), and continue to monitor baseline vital signs and complete secondary evaluation while awaiting EMS.
- When appropriate the football or lacrosse equipment may be removed prior to transport.
- Ideally all equipment should be removed at the earliest possible time from the equipment intensive athlete (Football, Men's Lacrosse etc.) **but** only if at least 3 rescuers trained and experienced are available on-site or at the earliest possible time after enough trained individuals arrive.
- WHEN the equipment is removed from a suspected spinal injury patient/athlete, a one-piece rigid cervical collar should be utilized to aid c-spine stability.

When to Use Spinal Motion Restriction/Immobilization:

- NEXUS criteria or Canadian C-Spine rules
- Blunt trauma or high energy MOI
- Altered level of consciousness or any of the following
- Drug or alcohol intoxication
- Inability to communicate
- Distracting injury
- Mid-line spinal pain and/or tenderness
- Focal neurologic signs and /or symptoms
- Numbness and/or motor weakness
- Anatomic deformity of the spine

Spine Immobilization

** Local EMS protocol and the availability of rescuers will dictate which spine-boarding method will be utilized (Log Roll, Lift & Slide, or 6+ Man Lift)

6+ /8+ Man Lift (*this is the preferred method for the supine injured athletes to be immobilized.)

- As described by the Inter-Association Task Force, the “6+/8+ lift technique” requires 1 person to immobilize the head and neck and 6 individuals (1 positioned on each side of the chest, pelvis, and legs) to assist with the lift. The eighth person will be in-charge of spine board placement.
- The person providing manual in-line stabilization guides the procedure and directs the others to lift the involved athlete from 4 to 6 in (10.16 to 15.24 cm) off the ground in a coordinated fashion.
- This provided clearance for an additional rescuer to slide the spine board into place from the foot end of the athlete.
- To complete the procedure, the injured athlete is lowered carefully onto the spine board in a coordinated manner.
- Once positioned onto long spine board, the athlete's torso and legs shall be secured, Athlete's arms should be left free from long spine board straps to facilitate vital sign monitoring and IV access. Athlete's wrists may be secured together in front of the body with Velcro strap or tape once secured to long spine board.
- Once torso and legs are secured, the head should be secured last. If necessary, padding should be applied under the athlete's head to fill any voids and maintain neutral in-line position. The head should be secured with lateral restraint pads and then secured to board with tape over forehead and at chin.
- Following securing athlete to board, neurological status should be reassessed.
- The secondary survey should be completed with baseline vital signs (reassessed every 5 minutes), head-to-toe survey, and SAMPLE history.
- Athlete should be transported to the most appropriate emergency medical facility.

Log Roll:

- If possible, a correctly sized rigid cervical collar should be placed on athlete prior to moving.
- When moving a suspected spine-injured athlete, the head and trunk should be moved as a unit by securing the athlete to a long spine board. Log-roll maneuver should be used to place the athlete on the long spine board. It is ideal that at minimum three (3) rescuers with preferably five to six (5-6) be in place to perform the log roll procedure.
- The rescuer controlling c-spine stabilization will be in command of log roll maneuver and long spine board immobilization.
- The log roll maneuver with the support personnel performing the “push technique” is the preferred method for placing the injured athlete onto the spine board.
- The log roll maneuver with the support personnel performing the “pull technique” is the preferred method for placing the injured athlete onto the spine board in the event the athlete is up against an obstacle such as a wall etc.
- Once positioned onto long spine board, the athlete's torso and legs shall be secured, Athlete's arms should be left free from long spine board straps to facilitate vital sign monitoring and IV access. Athlete's wrists may be secured together in front of the body with Velcro strap or tape once secured to long spine board.
- Once torso and legs are secured, the head should be secured last. If necessary, padding should be applied under the athlete's head to fill any voids and maintain neutral in-line position. The head should be secured with lateral restraint pads and then secured to board with tape or strapping over forehead and at chin.
- Following securing athlete to board, neurological status should be reassessed.
- The secondary survey should be completed with baseline vital signs (reassessed every 5 minutes), head-to-toe survey, and SAMPLE history.
- Athlete should be transported to the most appropriate emergency medical facility.

3.

Lift & Slide:

- With the 4-person L & S, 1 individual maintains manual, in-line stabilization of the head and neck, while the 3 other rescuers straddled the injured athlete in preparation for lifting the upper torso, hips, pelvis, and lower extremities.
- The rescuer controlling c-spine stabilization will be in command of the Lift & Slide maneuver and long spine board immobilization.
- A fifth assistant will be responsible for placement of the spine board.
- When all participants were ready, the individual stabilizing the head and neck will direct the others to raise the athlete off the ground to enable the remaining rescuer to slide the spine board under the athlete from the foot end.
- To complete the procedure, the injured athlete is settled gently into place on the spine board in a coordinated manner.
- Once positioned onto long spine board, the athlete's torso and legs shall be secured, Athlete's arms should be left free from long spine board straps to facilitate vital sign monitoring and IV access. Athlete's wrists may be secured together in front of the body with Velcro strap or tape once secured to long spine board.
- Once torso and legs are secured, the head should be secured last. If necessary, padding should be applied under the athlete's head to fill any voids and maintain neutral in-line position. The head should be secured with lateral restraint pads and then secured to board with tape or a strapping over forehead and at chin.
- Following securing athlete to board, neurological status should be reassessed.
- The secondary survey should be completed with baseline vital signs (reassessed every 5 minutes), head-to-toe survey, and SAMPLE history.
- Athlete should be transported to the most appropriate emergency medical facility.

Additional Guidelines for the Care of Spine-Injured Football Athlete

- The facemask should be removed prior to transportation, regardless of current respiratory status. Tools for facemask removal (FM Extractor, Drill, Portable Electric Screwdriver, manual screwdriver Anvil Pruners, or ratcheting PVC pipe cutter) should be readily accessible. Face mask style will affect which tool is selected. Some helmets may have face-mask quick-release attachments as well.
- All loop straps of the facemask should be cut, and the facemask removed from the helmet, rather than being retracted.
- The football helmet and chin strap should only be removed if: 1) the helmet and chin strap do not hold the head securely, such that immobilization of the helmet does not immobilize the head; 2) the design of the helmet and chin strap is such that, even after removal of the facemask, the airway cannot be controlled nor ventilation provided; 3) the facemask cannot be removed after a reasonable period of time; or 4) the helmet prevents immobilization for transportation in an appropriate manner.
- If the helmet must be removed, spinal immobilization must be maintained while removing. In most circumstances, it may be helpful to remove cheek padding and/or deflate air padding prior to helmet removal where applicable.
- Shoulder pads do not necessarily have to be removed on site. The front of the shoulder pads can be opened to allow access for CPR and defibrillation. Some shoulder pads may even be equipped with 'rip cord' quick release devices as well.
- Should either the helmet or shoulder pads be removed - or if only one of these is present- appropriate spinal alignment must be maintained.
- WHEN the sports equipment is removed from a suspected spinal injury patient/athlete, a one-piece rigid cervical collar should be applied to aid c-spine stability.

** Ideally all equipment should be removed at the earliest possible time from the equipment intensive athlete (Football, Men's Lacrosse etc.) **but** only if at least 3 rescuers trained and experienced are available on-site or at the earliest possible time after enough trained individuals arrive.

4.

** Local EMS protocol and the availability of trained rescuers will dictate which spine-boarding method will be utilized.

Procedures for Training in Spine Immobilization:

Personnel should review signs and symptoms of spine injury and complete a training session each year with in-line stabilization, rigid cervical collar application, log roll maneuver, and long spine board packaging. Personnel providing football and lacrosse medical coverage should review facemask removal with appropriate tools, helmet removal and shoulder pad removal.

EATING DISORDER POLICY

A comprehensive array of interventions and educational strategies is imperative to meet the challenges in understanding and working with athletes who present with disordered eating or may be at risk. The key is to establish a network of qualified and knowledgeable professionals who can skillfully handle interventions, provide a seamless continuum of care, institute screening measures for early detection, and develop educational initiatives for prevention. The management of athletes is complex and requires interdisciplinary collaboration among physicians, dietitians, therapists, certified athletic trainers, administrators, and coaches to obtain desired outcomes. The certified athletic trainer is in a unique position to play a significant role as a caregiver, informed patient advocate, and educator and should be prepared to act accordingly.¹

Symptoms of disordered eating include rapid weight loss; exercise obsession; social withdrawal; obsession with weight, diet, and/or appearance; a consistent pattern of stress fractures and/or overuse injuries; avoidance of social eating situations; variable performance; cessation of menses and eating binges with disappearance after the binge.

Novant Health Sports Medicine recognizes the seriousness of disordered eating management and is sensitive to these issues regarding the welfare of student-athletes.

The purpose of the Novant Health Sports Medicine Student-Athlete Disordered Eating Protocol is to:

- Prevent the development of disordered eating in our student-athlete population through the education of our student-athletes and coaches,
- Identify and/or screen for potential disordered eating,
- Establish a protocol to treat, follow-up, and communicate with coaches and administrators about any potential cases, and
- Utilize a multidisciplinary approach to treat and recognize disordered eating.

Confidentiality is critical in caring for any sports medicine injury and the same is true with disordered eating. The student athlete must understand that there will be a team approach to assisting with the situation and many health care professionals may be involved.

Action Required

Student-Athlete approaches asking for help: coach, athletic trainer, strength coach, administration

Student-Athlete is suspected of disordered eating by the following: teammate, coach, athletic trainer, strength coach, administration

Intervention

Athletic trainer will discuss with coach. Coach must be supportive and communicate their concern by following the athletic trainer's recommendations for activity level and encourage the athlete for treatment. Athlete's parents are notified of the situation.

Athletic trainer meets with student-athlete and refers care to team physician or to another physician as recommended. Parents are involved in the decision making process.

Athletic trainer is allowed to remove athlete from activity prior to physician referral if athlete is susceptible to physical harm (severe dehydration, syncope, heat illness, etc).

Team physician/Referring physician will evaluate and determine if further referral is needed.

Treatment Plans

Recommended that mental health counseling is performed because of usual underlying psychological aspect.
*Student-athlete's insurance will determine where and who they shall see for counseling.

Dieticians help educate about nutritional needs, especially with training and competition needs (meal planning, nutritional counseling, body composition).
*Student-athlete's insurance will determine where and who they shall see for counseling.

If the student athlete has irregular menses then they will be referred to an OB/Gyn Specialist. *Student-athlete's insurance will determine where and who they shall see.



Medical Surveillance

Athletic trainer will set up a contract to establish criteria for the student athlete to be accountable. This contract will have the following:

- Base BMI for participation
- Minimum body weight for participation
- Attend weekly counseling sessions (if applicable)
- Attend periodic nutritionist evaluations (if applicable)
- Meet with team physician/Referring physician weekly (if applicable)



Monitor Compliance

If student-athlete is unwilling to meet criteria set by the medical providers, then they student-athlete may become temporarily disqualified from athletic participation.

AIR QUALITY

It is necessary to take precautions in the event the air quality rises into the unhealthy or higher levels. This could be due to smog, pollution, industrial accidents, smoke from nearby fires etc. It is also important to understand that even those individuals with no history of respiratory problems are affected by poor air quality. It is the intention, of the NH Sports Medicine Department to protect the student-athletes from the dangers of participating in athletic related activities while there is an air quality advisory. There are three reasons why otherwise healthy athletes, are at special risk for inhaling pollutants. First, as physical activity increases minute ventilation, the number of pollutants that are inhaled relative to when the athlete is at rest are increased. Second, during activity, a larger proportion of air is inhaled through the mouth, which bypasses the body's built-in nasal filtration system. Third, pollutants are inhaled more deeply and may diffuse into the bloodstream more quickly during physical activity. These concerns are exasperated in those athletes with pre-existing pulmonary or cardiac conditions (Carlisle and Sharp, 2001).

An important and standardized national air quality resource is the National Weather Service's Air Quality Forecast System. This system "provides the US with ozone, particulate matter and other pollutant forecasts with enough accuracy and advance notice to take action to prevent or reduce adverse effects." (Accessed 6/14/16; http://www.nws.noaa.gov/ost/air_quality/).

A key component of this forecast system is the NWS Air Quality Index (AQI). The AQI provides real-time monitoring and alerts in response to changing air quality levels. The AQI accounts for five different pollutants, including 1) ground-level ozone, 2) particle pollution (also known as particulate matter), 3) carbon monoxide, 4) sulfur dioxide, and 5) nitrogen dioxide. Of these, ground-level ozone and particulate matter are the most common and most concerning pollutants for outdoor physical activity. The AQI is a single number, presented on a scale of 0 – 500, where 0 indicated no air quality problems and 500 indicates the most hazardous levels of air pollution.

I. Chain of Command

The responsibility for terminating an athletic activity in the event of poor air quality lies with the athletic director in consultation with coaches and/or certified athletic trainers. If athletic contest is scheduled the game officials should also be included regarding suspension of the event. The Davidson County health department should be consulted regarding the AQ reading and forecast on a regular basis when air quality levels appear deleterious along with <http://www.airnow.gov>.

Notification

- A. The forecasted Air Quality Reading is a Forecast. When necessary, on days when the forecasted reading is at a Health Advisory (Red Flag), a real time call for Athletics will be made. The Athletics threshold exceeds that of the general student population. The threshold for athletics is an Air Quality Index (AQI) of 170+ for high school. The call will be made from the District Athletic Director's Office. The government air quality web site <http://www.airnow.gov> will be used to determine the real time conditions.

The real time call is made to ensure the safety of our students. And, to ensure our students are not needlessly denied participation opportunities. There are times when air quality goes from an orange flag to a red flag, and there are times air quality goes from a red flag to an orange flag. As the day goes on, the air can get better. During the warmer months, the air quality is worse in the afternoon hours, due to ozone and heat.

Students at every school level with special health problems shall follow the precautions recommended by their physicians and shall refrain from all vigorous and strenuous activities. Students with special health problems (i.e., cardiac, asthma, or any other respiratory problems) will be identified on the confidential health list prepared and distributed to the head coaches by the athletic trainer. Strenuous physical activities for all students should be reduced and less strenuous activities substitutes, e.g., running to walking. Sensitive athletes should curtail outdoor activities and everyone else should limit prolonged outdoor exertion.

AIR QUALITY AND HOT WEATHER PROCEDURES

Green Flag (AQI <50) -- Regular school activities

Yellow Flag (AQ =51-100) -- Regular school activities

Orange Flag (AQI = 101=150) -- Regular school activities

- a. All sensitive students and adults should avoid strenuous outdoor activities, and/or follow the advice of their physician.
- b. Athletics may continue with shortened outdoor practices to no more than 60 minutes in length.
- c. Administrators should consider re-scheduling games/contests.

Red Flag (AQI = 151>) – Unhealthy air quality

- a. No physical activity
- b. Athletics are canceled; no practices, no games; classroom chalk talk is okay.

ADVERSE MEDICAL EVENTS

Novant Health athletic trainers will make all attempts to avoid and prevent adverse medical events. Proper safety, common sense and good judgement will be applied daily. The key is to follow and adhere to all best practices and procedures for student athlete health care and safety.

Patient Safety Definitions

- **Medical error**, defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.
 - **Adverse event**, defined as an injury caused by medical management rather than by the underlying disease or condition of the patient.
 - **Preventable adverse event**, defined as an adverse event injury that could have been avoided because of an error or system design flaw.
 - **Ameliorable adverse event**, defined as an injury whose severity could have been substantially reduced if different actions or procedures had been performed or followed.
 - **Negligence**, defined as whether the care provided failed to meet the standard of care reasonably expected of an average physician qualified to take care of the patient in question.
 - **Error of omission**, occurs when a necessary procedure or intervention failed to be performed leading to injury, morbidity or mortality to the patient involved
 - **Error of commission** occurs when a necessary procedure or intervention is performed but done so improperly leading to injury, morbidity or mortality to the patient involved.
1. Most medical errors do not result in medical injury, though some do, and these are termed preventable adverse events.
 2. Many adverse events are neither preventable nor ameliorable.
- For example, an **unavoidable adverse event** can occur from an unknown drug reaction in a patient or student athlete who received the appropriate administration of a particular OTC drug for the first time.
 - However, if a drug reaction occurred in a patient or student athlete who knowingly had a previous allergic reaction to that OTC drug, the adverse event would be considered preventable, and might be considered **negligent**.

COMMON MEDICAL ADVERSE EVENTS- HEALTHCARE RELATED

Athletic Training Clinical Events

Examples: Wound debridement in the athletic training room, physician injections or suturing etc. could develop into an adverse medical event.

Product or Device Events

Examples: Patient death or serious injury associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Devices include *therapeutic modalities* and whirlpools etc.

Patient Protection Events

Example: A student-athletes who does not have decision-making capacity, discharged to the wrong person or not providing correct information to parent/guardian regarding concussion home care.

Care Management Events

Examples: Patient death or serious injury associated with a fall while being cared for in a facility; improperly fitted crutches or issuing crutches with missing screws and wing nuts that result in a patient falling and getting hurt.

Environmental Events

Examples: Patient death or serious injury associated with a burn incurred from any source while being cared for in a facility; (Ex. Hydrocollator, EMS therapy, Whirlpool etc.)

Potential Criminal Events

Examples: Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider or athletic training personnel; Death or serious injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility. (Example: Athletic Trainer has physical altercation with an athlete)

MEDICAL INCIDENT – ADVERSE EVENT REPORT FORM

Date of incident: _____ Time: _____ AM/PM Location: _____

Name of injured person: _____

Address: _____

Phone Number(s): _____

Date of birth: _____ Male _____ Female _____

Who was injured person? (Circle one) Coach Student Athlete Team: _____

Type of injury: _____

Details of incident: _____

(Use additional sheet or backside of this form as needed)

Witness Name: _____ Phone #: _____

Witness Name: _____ Phone #: _____

Injury requires physician/hospital visit? Yes ____ No ____

Name of physician/hospital: _____

Address: _____

Physician/hospital phone number: _____

Signature of injured party _____ Date: ____/____/____

*No medical attention was desired and/or required.

Signature of injured party

Date

Return this form to Bob Casmus, M.S., ATC – Supervisor of Athletic Trainers within 24 hours of incident.
Contact Information: rcasmus@novanthealth.org or phone (O) 336-718-5767 or (C) 704-642-8232

ACCIDENT/INCIDENT REPORT & INVESTIGATION FORM

Please attach to Medical Incident Report Form and Complete as Applicable

What body part was affected? (Please note left or right where applicable)

- () Head () Face () Eyes () Ears () Mouth () Neck () Shoulders
() Chest () Abdomen () Pelvis () Back –upper () Back-lower () Groin
() Buttocks () Fingers () Hands () Wrist () Forearm () Elbow () Upper Arm
() Toes () Feet () Lower leg () Knee () Thigh () Skin () Systemic
() Other

Describe: _____

How was it affected?

- () Abrasion () Avulsion/Amputation () Bruise/Contusion () Burn () Pain
() Loss of Hearing () Crushed () Laceration () Dermatitis () Fracture () Inflammation
() Loss of Sight () Heart Attack/Stroke () Infection () Loss of Feeling or Movement
() Bloodborne Pathogen Exposure () Puncture () Poisoning () Strain/Sprain
() Swelling () Trauma () LOC () Concussion () Psychological () Other

Describe: _____

What object or substance directly caused the harm? _____

What immediate corrective actions were taken: _____

2.

Root Causes and Contributing Factors: _____

Why did any of the above items exist: _____

Long Term Corrective Actions being taken and target completion date:

_____	_____	____/____/____
Injured Party Name	Injured Party Signature	Date

_____	_____	____/____/____
Your Name	Your Name	Date

_____	_____	____/____/____
Supervisor Name	Supervisor Signature	Date

_____	_____	____/____/____
* Witness Name	* Witness Signature	Date

*Witness only if required per supervisor decision

Return this form to Bob Casmus, M.S., ATC – Supervisor of Athletic Trainers
Contact Information: rcasmus@novanthealth.org or phone (O) 336-718-5767 or (C) 704-642-8232

Accident/Incident Report Investigative Form

Analysis Checklist

Potential Causes (check all that apply)

1. Mechanical Controls (Guards/Devices)

- ☐ Were not designed to prevent this circumstance
- ☐ Were available but not in place at time of accident
- ☐ Were in place but did not work
- ☐ Were available but intentionally not used at time of accident
- ☐ Were not available
- ☐ Warning devices did not function
- ☐ Warning devices functioned but were ignored
- ☐ Not applicable

2. Design/Construction

- ☐ Poor job layout or design
- ☐ Adequate space not provided for proper positioning
- ☐ All necessary equipment to complete the job was not available
- ☐ Inadequate ventilation, illumination, surfacing is not provided
- ☐ Improper tool used
- ☐ No applicable

3. Inspection Program/Defective Equipment

- ☐ Equipment not adequately inspected or was defective
- ☐ Processes/operations were not adequately reviewed
- ☐ Inspectors not adequately trained to recognize hazard
- ☐ Preventive maintenance did not address this circumstance
- ☐ Inspections do not frequent enough to detect this problem
- ☐ Problem was recognized, but work order was never written
- ☐ Not applicable

4. Policy/Procedure/Work Instructions

- ☐ There is not a written policy or work instruction covering these circumstance but there should be
- ☐ There is written instruction or policy, but they were not followed
- ☐ There is a policy, but it does not correctly address this circumstance
- ☐ Not applicable

5. Environmental /Storage Factors

- ☐ Poor housekeeping
- ☐ Insecure storage
- ☐ Poor illumination
- ☐ Improper ventilation
- ☐ Leaking containers/piping/pumps
- ☐ Not applicable

6. Materials Handling/Process Operations/Maintenance

- ☐ Mixing or using the wrong chemical
- ☐ Over exertion in handling containers
- ☐ Improper opening or closing procedures
- ☐ Failure to follow lockout, confined space, hot work or on-line leaking procedures
- ☐ Overloading equipment in process
- ☐ Not applicable

7. Similar Accidents/Work Practices/Conditions

- ☐ Similar accidents have occurred without investigation
- ☐ Similar accidents or poor work practices have occurred without corrective action
- ☐ Employees/management have tolerated the unsafe practice
- ☐ Not applicable

8. Training

- ☐ Employee not adequately trained in safe work procedures rules, policies, including chemical or biohazards
- ☐ Employee not adequately trained in hazard identification
- ☐ Employee not adequately trained in job/equipment specific operation
- ☐ Supervisor not adequately trained
- ☐ Employee was trained, but did not utilize learned skills or information

9. Human Factor Behavior

- ☐ Not wearing PPE
- ☐ Design procedures to not interface well with human characteristics. Make job more difficult to complete
- ☐ Job creates too much physical stress
- ☐ Job creates too much mental stress
- ☐ Job creates too much physical stress
- ☐ Inadequate time to complete the job
- ☐ Problem pointed out to members of management but never corrected
- ☐ Employee was not periodically observed on the job
- ☐ Job is designed such that it is easier to perform unsafely
- ☐ Job does not fit person
- ☐ Job causes awkward postures or positioning
- ☐ Job overloads employee with information
- ☐ Job requires employee to work too rapidly

10 Supervision

- ☐ Work site not adequately supervised
- ☐ Necessary supportive services were not available
- ☐ Not applicable

Sickle Cell Trait

Sickle cell trait is not a disease. Sickle cell trait is the inheritance of one gene for sickle hemoglobin and one for normal hemoglobin. Sickle cell trait will not turn into the disease. Sickle cell trait is a life-long condition that will not change over time. People at high risk for having sickle cell trait are those whose ancestors come from Africa, South or Central America, India, Saudi Arabia, and Caribbean and Mediterranean countries. Sickle cell trait occurs in about 8 percent of the U.S. African-American population and occurs between one in 2,000 to one in 10,000 in the Caucasian population. Most U.S. states test at birth, but most athletes with sickle cell trait don't know they have it. Red blood cells (RBC's) are normally round, circular or disc shaped. RBC's have hemoglobin component (helps carry oxygen) and platelets (helps in clotting). Person gets one gene for "sickling" hemoglobin and one gene for normal hemoglobin. People with sickle cell trait rarely have symptoms – because they have normal hemoglobin along with abnormal hemoglobin. With INTENSE or EXTENSIVE exercise, the hemoglobin can take a sickle shape or crescent shape. This affects oxygen carrying capacity to the cells! When athletes experience dehydration, infection, and low oxygen supply – The fragile RBCs assume a crescent shape causing RBC breakdown, poor flow of RBCs through blood vessels with poor oxygenation to the tissues! The "Sickling of the RBC's creates a "Log or Traffic Jam" which now results in: Ischemic Rhabdomyolysis in which broken down muscle cells get released into the bloodstream as well! This is a life-threatening situation!

Steps to Prevent Sickle Cell Collapse

- Know your sickle cell trait status.
- Engage in a slow and gradual preseason conditioning regimen.
- Build up intensity slowly while training.
- Set your own pace. Use adequate rest and recovery between repetitions, especially during "gassers" and intense station or "mat" drills.
- Avoid pushing with all-out exertion longer than two to three minutes without a rest interval or a breather.
- If one experiences symptoms such as muscle pain, abnormal weakness, undue fatigue, or breathlessness, stop the activity immediately and notify your athletic trainer and/or coach.
- Stay well always hydrated, especially in hot and humid conditions.
- Avoid using high-caffeine energy drinks or supplements, or other stimulants, as they may contribute to dehydration.
- Heat, dehydration, altitude, and asthma can increase the risk for and worsen complications associated with sickle cell trait, even when exercise is not intense.
- Athletes with sickle cell trait should not be excluded from participation as precautions can be put into place.
- Maintain proper asthma management.
- Refrain from extreme exercise during acute illness, if feeling ill, or while experiencing a fever.
- Beware when adjusting to a change in altitude, e.g., a rise in altitude of as little as 2,000 feet. Modify your training and request that supplemental oxygen be available to you.
- Seek prompt medical care when experiencing unusual physical distress.

What are the signs or symptoms of exercise-related Sickle Cell illness or complications?

- Muscle burning or tenderness.
- Muscle weakness or pain.
- Muscle cramps.
- Rapid breathing without wheezing.
- Feeling overheated.
- Inability to cool, reduced sweating at rest
- Prolonged exhaustion or fatigue.

What should you do if you experience any of these signs or symptoms of distress while exercising:

- Immediately stop exercising.
- Report the symptoms immediately to the coach, athletic trainer, or person overseeing your training.
- Rest and re-hydrate.
- Move out of the heat, cool down with wet towels or ice; and
- Seek prompt medical care if symptoms worsen or do not improve with rest.

Emergency Care

1. Check vital signs.
- 2) Administer high-flow oxygen, 15 lpm (if available), with a non-rebreather face mask.
- 3) Cool the athlete, if necessary.
- 4) If the athlete is obtunded or as vital signs decline, call 911, attach an AED, and be ready to perform CPR.
- 5) Tell EMS and emergency room personnel to expect explosive rhabdomyolysis and grave metabolic complications.
- 6) Proactively prepare by having an Emergency Action Plan and appropriate emergency equipment for all practices and competitions

SKIN INFECTIONS

Skin infections are common in athletics as participants are exposed to dirt, sweat, bodily contact and close quarters that promote skin-to-skin and bodily secretion contact between athletes. Skin diseases fall into three basic categories based on the type of infectious agent: fungal, viral, and bacterial. Skin infections tend to be more prominent in the sport of wrestling.

Fungal infections:

Fungal infections are caused by dermatophytes, fungal organisms living in soil, on animals, or on humans. The infectious organisms responsible for fungal infections include trichophyton tonsurans and trichophyton rubrum. Tinea capitis – a common fungal infection of the scalp manifested by gray scaly patches accompanied by mild hair loss in many cases. Tinea corporis – a fungal infection on the body commonly referred to as “ring worm,” a name gleaned from its characteristic ring-like appearance. Tinea cruris – a fungal infection in the groin area commonly referred to as “jock itch.” Tinea pedis – the most common fungal infection in humans in North America and Europe, which affects the feet, and is commonly referred to as “athlete’s foot.” Athletes in non-contact sports or with localized cases of fungal infections may initially be treated with topical preparations for two to four weeks. More widespread, inflammatory, or otherwise difficult-to-treat cases may require the use of systemic antifungal drugs which can have substantial side effects.

Viral infections:

Viral infections are caused by the herpes simplex virus and molluscum contagiosum virus. Herpes simplex virus – HSV is a painful, often recurring, infection consisting of clusters of small fluid filled sacs on a base of red skin. Viruses may remain dormant in the body for years manifesting themselves in situations of depressed immunity and stress. Molluscum contagiosum – MC is a highly infectious viral disease caused by the poxvirus. It is common in children and is manifested by smooth flesh-colored, dome-shaped bumps with a depression (umbilication) in the center. Treatments include destruction of the lesions with a sharp curette or antiviral medications, depending on the virus for which the athlete is treated.

Bacterial infections:

Humans are natural hosts for many bacterial species that colonize the skin as normal flora. Staphylococcus aureus and streptococcus bacteria account for a wide variety of bacterial infections. Predisposing factors to infection include minor trauma, preexisting skin disease, poor hygiene, and depressed immune system of the host. Impetigo – a common bacterial infection caused by staph a., characterized by thin-walled sacs of fluid that rupture into a honey-colored crust commonly occurring on the face. Folliculitis/furunculosis/carbunculosis – Folliculitis is a superficial infection of the hair follicles characterized by redness, fluid, or pus-filled sacs at the base of hair follicles. Furuncles are deeper infections of the hair follicle characterized by inflamed nodules that drain fluid, which can join to form larger nodules called carbuncles. Methicillin resistant staphylococcus aureus (MRSA) – strain of staph a. that has acquired a specific gene (mecA) making it resistant to common antibiotic therapy. MRSA presents initially as standard bacterial infections and is commonly confused with spider bites MRSA was previously only found in hospital settings, but now common in community settings (CA-MRSA). MRSA is reported to be the most frequent cause of skin infections presented to emergency rooms across the country. Affected athletes must complete, at minimum, a 72-hour course of directed antibiotic therapy; also, due to the communicable nature of bacterial infections, active lesions must not be covered to allow for participation in sports.

Preventive Measures:

1) School administrators should assist in preventing skin infections in sports teams by providing:

- Warm water, soap, and paper towels in locker rooms and bathrooms
- Environmental Protection Agency (EPA) registered disinfectants
- Training and education for staff, coaches, and athletes

2) All athletes should:

- Maintain a good personal hygiene and shower immediately with an antimicrobial soap and water after every competition and practice.
- Wash all soiled clothing after each practice and disinfect personal gear (knee pads, braces, etc.) daily as per manufacturer’s recommendations

- Not share towels, athletic gear, or personal hygiene products (razors, clippers) or water bottles with others
 - Refrain from full body cosmetic shaving (Chest, Arms, and/or Abdomen)
 - Avoid using whirlpools and common tubs if they have open wounds, scrapes, or scratches
 - Notify an athletic trainer, coach, parent, or guardian if they have any skin lesions, cuts or abrasions prior to any competition or practice
 - Cover acute, uninfected wounds, such as abrasions or lacerations with a semi occlusive or occlusive dressing until healing is complete
- 3) Athletic trainers are the first line of defense against spread of these infections in their teams. Athletic trainers should:
- Be vigilant with their athletes about following infection control policies to minimize the transmission of infectious agents
 - Be able to identify the signs and symptoms of common skin diseases in athletes
 - Be familiar with proper cleansing, treatment, and dressing of minor cuts and abrasions
 - Be able to refer suspected cases of skin infections to a healthcare provider for evaluation before participating in training or competition
- 4) Hand Hygiene: is the single most important practice in reducing the transmission of infectious agents. Hands should be decontaminated before and after touching exposed skin of an athlete. Wash hands when visibly dirty. If hands are not visibly dirty you may use alcohol-based hand rub
- 5) Environmental measures: A clean environment must be maintained in the athletic training facility, locker rooms, and all athletic venues
- Cleaning and disinfection of frequently touched surfaces (wrestling mats, locker rooms, benches, etc.) must be maintained
 - A detailed documented cleaning schedule should be implemented for all areas and reviewed regularly
 - Type of routinely used disinfectants should be EPA registered and manufacture's recommendations for amount, contact time, and dilution should be followed.

When a suspected infection occurs:

- 1) Refer the athlete to a physician or healthcare provider.
- 2) Begin a report listing of persons with skin conditions. Update the line list daily or as needed for the duration of the outbreak.
- 3) Use the report to track the progress of the outbreak and to adjust your control measures
- 4) Implement appropriate control measures including:
 - All team members should be evaluated by athletic training staff to identify additional cases and refer to a health-care professional
 - Coaches, officials, and health-care professionals must follow the National Collegiate Athletic Association (NFHS) and NCHSAA exclusion and return to play guidelines. This includes appropriate physician release and skin-check forms.
 - Environmental cleaning should be reviewed, monitored, and increased in frequency
 - Special attention should be paid to high touch areas such as wrestling mats, locker rooms, benches, etc.
- 5) Provide supplementary education to athletes, coaches, and custodial staff on hand hygiene, personal hygiene, and equipment sharing.
- 6) Utilize universal precautions including the use of gloves when inspecting questionable skin infections and hand washing procedures.

Family	Specific Condition	Clinical Features
Fungal infections	Tinea capitis	Often presents as gray, scaly patches accompanied by mild hair loss
	Tinea corporis	Presents with a well-defined, round, erythematous, scaly plaque with raised borders; however, tinea corporis gladiatorum (tinea corporis in wrestlers) frequently presents with a more irregular lesion
Viral infections	Herpes simplex	Lesions are typically found on the head, face, neck, or upper extremities and present as clustered, tense vesicles on an erythematous base.
	Molluscum contagiosum	Typically presents as umbilicated, or deled, flesh-colored to light-pink pearly papules, measuring 1–10 mm in diameter
Bacterial infections	Impetigo	Bullous impetigo presents on the trunk or the extremities with raised blisters that rupture easily, resulting in moist erosions surrounded by a scaly rim. Nonbilious impetigo presents with thin-walled vesicles that rupture into a honey-colored crust
	Folliculitis	Presents as papules and pustules at the base of hair follicles, especially in areas that have been shaved, taped, or abraded
	Furuncles, carbuncles	Furuncles present as tender areas that, over several days, develop a reddened nodular swelling; carbuncles present as the coalescence of multiple furuncles in a deep, communicating, purulent mass
	MRSA	CA-MRSA initially presents similarly to other bacterial infections. Furuncles, carbuncles, and abscesses are the most frequent clinical manifestations. Often CA-MRSA lesions are confused with spider bites. Lesions may begin as small pustules that develop into larger pustules or abscesses with areas of erythema and some tissue necrosis

Return to Play Guidelines:

Condition	Return-to-Play Guidelines
Tinea corporis	Minimum 72 h topical fungicide terbinafine (Lamisil) or naftifine (Naftin). Lesions must be covered with a gas-permeable dressing followed by underwrap and stretch tape
Tinea capitis	Minimum 2 wk systemic antifungal therapy
Herpes simplex (primary)	Free of systemic symptoms of viral infection (fever, malaise, etc). No new lesions for at least 72 h. No moist lesions: all lesions must be covered with a firm, adherent crust. Minimum 120 h systemic antiviral therapy. Active lesions cannot be covered to allow participation
Herpes simplex (recurrent)	No moist lesions: all lesions must be covered with a firm, adherent crust. Minimum 120 h systemic antiviral therapy. Active lesions cannot be covered to allow participation
Molluscum contagiosum	Lesions must be curetted or removed. Localized lesions may be covered with a gas-permeable dressing followed by underwrap and stretch tape
Furuncles, carbuncles, folliculitis, impetigo, cellulitis, or methicillin-resistant Staphylococcus aureus	No new lesions for at least 48 h. Minimum 72 h antibiotic therapy. No moist, exudative, or draining lesions. Active lesions cannot be covered to allow participation

NCHSAA INFORMATION:

Bacterial Diseases (impetigo, boils): To be considered “non-contagious,” all lesions must be scabbed over with no oozing or discharge and no new lesions should have occurred in the preceding 48 hours. Oral antibiotic for three days is considered a minimum to achieve that status. If new lesions continue to develop or drain after 72 hours, CA-MRSA (Community Associated Methicillin Resistant Staphylococcus Aureus) should be considered and minimum oral antibiotics should be extended to 10 days before returning the athlete to competition or until all lesions are scabbed over, whichever occurs last.

Herpetic Lesions (Simplex, fever blisters/cold sores, Zoster, Gladiatorum): To be considered “non-contagious,” all lesions must be scabbed over with no oozing or discharge and no new lesions should have occurred in the preceding 48 hours. For primary (first episode of Herpes Gladiatorum), athletes should be treated and not allowed to compete for a minimum of 10 days. If general body signs and symptoms like fever and swollen lymph nodes are present, that minimum period of treatment should be extended to 14 days. Recurrent outbreaks require a minimum of 120 hours or full five days of oral anti-viral treatment, again so long as no new lesions have developed, and all lesions are scabbed over.

Tinea Lesions (ringworm scalp, skin): Oral or topical treatment for 72 hours on skin and 14 days on scalp.

Scabies, Head Lice: 24 hours after appropriate topical management.

Conjunctivitis (Pink Eye): 24 hours of topical or oral medication and no discharge.

Molluscum Contagiosum: 24 hours after curettage. Wrestlers - Upon treatment with curettage and hyfrecator, may cover with bio-occlusive and wrestle immediately.

Note to Appropriate Health-Care Professionals: Non-contagious lesions do not require treatment prior to return to participation (e.g., eczema, psoriasis, etc.).

NCHSAA FORMS:

<https://www.nchsaa.org/parents-students/health-and-safety>

Skin Condition Physician Release Form - Wrestling

Skin Condition Physician Release Form - Other Sports

<https://www.nchsaa.org/parents-students/health-and-safety>

Skin Disease Flyer

Wrestling Skin Check Guidelines

Wrestling Skin Check Presentation

CATASTROPHIC INCIDENT GUIDELINE

BISHOP MCGUINNESS HIGH SCHOOL ATHLETIC DEPARTMENT

CATASTROPHIC INCIDENT GUIDELINES

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Catastrophic Incident Guidelines

I. Introduction and Definition of Catastrophic Incident

The Bishop McGuinness High School Athletic Department Catastrophic Incident Guideline will be activated when the following catastrophic incidents occur:

1. *Sudden Death of a Student-Athlete, Coach or Staff Member*
 - Death during competition, practice, or conditioning
 - Death during travel for an official Catawba College activity or during personal travel (ex. automobile or airline accident)
 - Non-athletic accidents (ex. falls at home or work)
 - Unknown medical anomalies (ex. heart attack, stroke, illness)
 - Victim of a crime (ex. homicide)
 - Suicide
2. *Disability or Quality of Life Altering Injuries*
 - Either during Bishop McGuinness High School Athletic Department participation and/or travel, OR during non-athletic activities
 - Spinal cord injury that results in partial or complete paralysis
 - Loss of paired organ
 - Severe head injury
 - Injuries resulting in severely diminished mental capacity or other neurological injury that results in the inability to perform daily functions (ex. coma)
 - Irrecoverable loss of speech, hearing or sight or loss of both arms/legs or one arm or one leg

II. Catastrophic Injury Management Team (CIMT)

1. Dr. Tracy Shaw – Principal
2. Jeff Stoller – Director of Athletics
3. Brittany Price MS, LAT , ATC – NH Athletic Trainer
4. Charles Elmore– Davidson County Athletic Director
5. Diocese of Charlotte– Superintendent
6. Head Coach of sport involved with the catastrophic incident
7. Additional personnel as deemed appropriate by CIMT

III. Immediate Action Plan

The following action plan will appropriately apply steps to manage a catastrophic incident. While applying these steps, Bishop McGuinness High School Athletic Personnel will keep in mind the following goals:

1. Get pertinent facts regarding the incident accurately and expeditiously
2. Accurately document all events, especially list all participants and witnesses
3. Secure any or all available materials/equipment involved
4. Respect the dignity of the individuals involved
5. Immediate and *on-going* communication within the catastrophic incident management team (CIMT)
6. Only members of the CIMT, or individuals they designate are to speak on the incident to family members, media, other staff members, student-athletes, or coaches. *NO ONE ELSE* has clearance to speak on the incident.
7. Instruct student-athletes they are not to speak to *anyone* regarding the incident.
8. Any communication with the media is handled jointly through the Executive Director of Communications and Strategic Planning for the Davidson County Schools.
9. NO RELEASE of any information will be made until parents/guardians are informed.

IV. Chain of Command & Responsibilities

After being informed of a catastrophic incident, the following individuals should be notified to commence responsibilities:

- During Bishop McGuinness High School Athletic Department participation or travel:
Director of Athletics and the NH Athletic Trainer

DIRECTOR of ATHLETICS

- Notifies the Charles Elmore – Davidson County Director of Athletics
- Notifies the NH Athletic Trainer
- Notifies the appropriate head coach of the team involved
- Notifies his/her principal

NH ATHLETIC TRAINER

- Notifies the Director of Athletics and Team Physician
- Notifies Head Coach if incident occurs during non-practice participation or when coach may not be present
- Coordinates along with team physician, communication with any medical personnel and/or physicians involved in the catastrophic incident medical care

TEAM PHYSICIAN

- Communication with the Director of Athletics and the Head Athletic Trainer on medical facts and events
- Communicates with any medical personnel and facilities regarding the catastrophic incident

CHIEF COMMUNICATIONS OFFICER (Executive Director of Communications and Strategic Planning for Davidson County Schools)

- Coordinate all information to be given to the media

HEAD COACH OF INVOLVED TEAM

- Inform assistant coaches and team of the catastrophic incident
- Remind assistant coaches and team not to speak to the media or anyone else regarding the catastrophic incident

ADDITIONAL PERSONNEL

Depending upon the nature of the catastrophic incident, the following areas or departments maybe involved or assist with the CIMT:

Charles Elmore – Davidson County Athletic Director

- Coordinate communication with members of the CIMT

Superintendent – Davidson County Schools

- Coordinate communication and actions with members of the CIMT

Davidson County Schools Risk Manager and/or Legal Counsel

- Notify Insurance Carrier
- Work collaboratively with the CIMT

V. Criminal Circumstances (ex. Accident, Assault, Homicide, Suicide)

In the event of a criminal circumstance occurring on-campus, the SRO or local law enforcement is notified and becomes part of the CIMT.

SRO

- Communicates and collaborates with local law enforcement officials
- Communicates information to the CIMT

In the event of a criminal circumstance occurring off-campus at an official Davidson County High Schools athletic event (ex. away game), the following steps will apply:

- Notification is made to the Director of Athletics
- The Director of Athletics notifies the CIMT
- CIMT members carry out assigned duties as part of the catastrophic incident management guidelines
- The CIMT and related personnel involved work cooperatively with law enforcement officials

VI. Away Contest – Coaches, Administrators and Staff Members

In the event of a catastrophic incident (non-criminal) occurring off-campus at an official Davidson County athletic event (ex. away game), the following steps will apply

- Immediate notification of the Director of Athletics and Head Athletic Trainer
- Work with local hospital, sports medicine staff, and athletic department to assist and gather information to update the CIMT
- Head coach and/or assistant coach or athletic trainer remains on site after team departs to coordinate communication and arrangements

VII. Summary Chronicle

- A detailed written summary chronicle will be prepared following any catastrophic incident which identifies and explains the activities of those involved, those who participated in and those who responded to the incident
- This chronicle will be kept on file and used to critique the process, its efficiency and effectiveness, and will be used as the basis for review of procedures

IMPORTANT PHONE NUMBERS

Name	Office	Home	Cell
Jeff Stoller- AD	336-564-1010		336-707-3252
Brittany Price MS, LAT, ATC– NH AT	336-564-1010 ext 1257		336-207-3735
Dr. Tracy Shaw- Principal	336-564-1010		
Diocese of Charlotte- Superintendent			
John L. Sullivan - County Athletic Director	336-784-4000		
- Chief Communications Officer			
- Risk Manager			
- Legal Counsel			
Head Coaches			
Charlie Jones- FB			336-430-6895
Ray Alley- W Soccer			336-339-5135
Pat Bowen- Baseball			336-420-1834
Neil Hodges- M Soccer			336-575-6192
Kelli Houseknecht- Cheer			704-576-1041
Larry Ingram- M Tennis			336-706-9444
Ed Jackson- Wrestling			336-442-7049
Dwight Jacobs- T&F			336-772-0189
Shawn Jacobsen- Volleyball			336-462-0394
Catherine Lassiter- W Tennis			336-413-7967
Brian Robinson- W Basketball			336-671-1609
Shannon Robinson- M LAX			516-587-0439
Chris Scola- XC			856-979-1231
Dana St Claire- Swim			336-692-5320
Josh Thompson- M Basketball			336-508-2550
Kaila Tuccio- Golf			407-618-6364
First Responders/School Athletic Trainers			
Brittany Price MS, LAT, ATC– NH AT	336-564-1010 ext 1257		336-207-3735
Jeff Stoller- AD	336-564-1010		336-707-3252
Brian Smith - First Responder			336-471-9920

CATASTROPHIC INJURY PLAN – Brief Outline

When Catastrophic Event Occurs– Head Coaches

- Contact Athletic Director & Athletic Trainer

Contact Head Athletic Trainer and Team Physician (Athletic Trainer & Athletic Director)

- Work with medical specialist assisting the athlete.

Designate the athletics administrator as point person. (Athletic Director)

Contact family by appropriate Davidson County School representative individual.

- This will be determined by the Athletic Director
- Assist as needed

Coaches Hold meeting with athletes to discuss situation.

- **NO** outside discussion with media

Contact Principal, County Athletic Director, and Superintendent (Athletic Director)

Coaches, Support Staff and Administrators present at the event:

- Complete documentation of events with signatures of everyone involved in incident.

Coaches, Support Staff and Administrators present at the event:

- Collect and secure all equipment/materials involved.

Coaches, Support Staff and Administrators present at the event:

- Construct detailed timeline of events related to incident.

Involve appropriate counseling/ministerial personnel.

Assign athletic staff member to be always with family upon arrival and protect from outside persons.

Appendix #_1____

ATHLETIC TRAINING PROTOCOL

Name: Brittany Price MS, LAT, ATC

School: Bishop McGuinness High School
1725 NC-66 S
Kernersville, NC 27284

Novant Sports Medicine & Rehabilitation
Novant Heath Forsyth Medical Center
3333 Silas Creek Parkway
Winston-Salem, NC 27103

Prevention: A. Educate the appropriate patient(s)/student athletes about risks associated with participation and specific activities/athletic activities using effective communication techniques to minimize the risk of injury and illness. B. Interpret pre-participation and other relevant screening information in accordance with accepted guidelines to minimize risk of injury and illness. C. Instruct the appropriate patient(s)/student athletes about standard protective equipment by using effective communication techniques to minimize risk of injury and illness. D. Apply appropriate prophylactic and/or protective measures by using commercial products or custom-made devices to minimize risk of injury and illness. E. Identify safety hazards associated with activities, activity areas, and equipment by following accepted procedures and guidelines to make appropriate recommendations and to minimize the risk of injury and illness. F. Maintain clinical and treatment areas by complying with safety and sanitation standards to minimize risk of injury and illness. G. Monitor participants/student athletes/patients and environmental conditions by following accepted guidelines to promote safe participation. H. Facilitate physical conditioning by designing and implementing appropriate programs to minimize injury risk. I. Facilitate healthy lifestyle behaviors using effective education, communication, and intervention risk of injury and illness and promote wellness.

Clinical Evaluation and Diagnosis: A. Obtain a history through observation, interview, and/or review of relevant records to assess the pathology and extent of the injury, illness, or condition. B. Inspect the involved area(s) visually to assess the pathology and extent of the injury, illness, or health-related condition. C. Palpate the involved area(s) using standard techniques to assess the pathology and extent of the injury, illness, or health-related condition. D. Perform specific tests in accordance with accepted procedures to assess the pathology and extent of the injury, illness, or health-related condition. E. Formulate a clinical impression by interpreting the signs, symptoms, and predisposing factors of the injury, illness, or health-related condition to determine the appropriate course of action. F. Educate the appropriate patient(s)/student athletes about the assessment by communicating information about the current or potential injury, illness, or health-related condition to encourage compliance with recommended care. G. Share assessment findings with other healthcare professionals using effective means of communication to coordinate appropriate care.

Immediate Care: A. Employ life-saving techniques using standard emergency procedures to reduce morbidity and the incidence of mortality. B. Prevent exacerbation of non-life-threatening condition(s) using standard procedures to reduce morbidity. C. Facilitate the timely transfer of care for conditions beyond the scope of practice of the athletic trainer by implementing appropriate referral strategies to stabilize and/or prevent exacerbation of the condition(s) D. Direct the appropriate patient(s)/student athletes in standard immediate care procedures using formal and informal methods to facilitate immediate care. E. Execute the established emergency action plan using effective communication and administration practices to facilitate efficient immediate care. F. In the event of a serious injury, the following procedures will apply: 1. **Call 911 to activate the EMS** for transport to an emergency facility. 2. If not present at the athletic event the team physician will be called and made aware of the situation.

Treatment, Rehabilitation, and Reconditioning: A. Administer therapeutic and conditioning exercise(s) using standard techniques and procedures to facilitate recovery, function, and/or performance. B. Administer therapeutic modalities using standard techniques and procedures to facilitate recovery, function, and/or performance. C. Apply braces, splints, or assistive devices in accordance with appropriate standards and practices to facilitate recovery, function, and/or performance. D. Administer treatment for general illness and/or conditions using standard techniques and procedures to facilitate recovery, function, and/or performance. E. Reassess the status of injuries, illnesses, and/or conditions using standard techniques and documentation strategies to determine appropriate treatment, rehabilitation, and/or reconditioning and to evaluate readiness to return to a desired level of activity. F. Educate the appropriate patients/student athletes in the treatment, rehabilitation, and reconditioning of injuries, illness, and/or conditions using applicable methods and materials to facilitate recovery, function, and/or performance. G. Provide guidance and/or counseling for the appropriate patient(s)/student athletes in the treatment, rehabilitation, and reconditioning of injuries, illnesses and /or conditions through communication to facilitate recovery, function, and performance.

Organization and Administration: A. Establish action plans for response to injury or illness using available resources to provide the required range of healthcare services for patients, athletic activities, and events. B. Establish policies and procedures for the delivery of healthcare services following accepted guidelines to promote safe participation, timely care, and legal compliance. C. Establish policies and procedures for the management of healthcare facilities and activity areas by referring to accepted guidelines, standards, and regulations to promote safety and legal compliance. D. Manage human and fiscal resources by utilizing appropriate leadership, organization, and management techniques to provide efficient and effective healthcare services. E. Maintain records using an appropriate system to document services rendered, provide for continuity of care, facilitate communication, and meet legal standards. F. Develop professional relationships with appropriate patients/student athletes and entities by applying effective communication techniques to enhance the delivery of healthcare.

Professional Responsibility: A. Demonstrate appropriate professional conduct by complying with applicable standards and maintaining continuing competence to provide quality athletic training services. B. Adhere to statutory and regulatory provisions and other legal responsibilities relating to the practice of athletic training by maintaining and understanding of these provisions and responsibilities to contribute to the safety and welfare of the public. C. Educate appropriate patients and entities about the role and standards of practice of the athletic trainer through informal and formal means to improve the ability of those patients and entities to make informed decisions. D. Perform other specified tasks as directed by the team physician/medical director.

The undersigned physician and athletic trainer agree to abide by this protocol:

Physician Name: _____ Date: ____/____/____

Signature: _____

Address: _____

Athletic Trainer Name: _____ Date: ____/____/____

Signature: _____

Practice and Game Procedures for an Injured or Ill Student Athlete & General Return to Play Protocol

Decisions regarding the availability of the student athlete for practice or game competition require the cooperative efforts of the student athlete, Coach, Athletic Trainer, physician, parents, and the AD. These decisions should and will be based on sound medical judgments, with the outcome being proper athletic health care. The Athletic Trainer will attempt to provide quality athletic health care for the student athlete under the following guidelines:

- 1) If a student athlete is under the care of a physician, or a physician is present, the physician determines the ability of the student athlete to practice or compete in practice or game.
- 2) If the student athlete is NOT under a physician's care, and the Athletic Trainer is providing the primary care, then it becomes the responsibility of the athletic trainer to determine the ability of the student athlete to practice or compete.
 - a) The athletic trainer will convey a "no-play" decision to the appropriate coach if such a decision is made in the best interest for the student athlete's health and well-being.
 - b) Under no circumstances should any coach allow a student athlete to practice or compete until either they are cleared directly by the athletic trainer or there is written documentation by the physician that the student athlete is able to return to play.
 - i) Verbal communication from the physician to the athletic trainer directly will be accepted on a 24-hour basis, written documentation is required for full clearance to return to play.
 - ii) A representation by the student athlete to the athletic trainer and/or coach will NOT meet the requirements for the student athletes to return to play.
 - iii) A "no-play" decision by the physician will always be followed. This decision may not be over-ruled by any coach at any time. All violations of this policy will be reported to the athletic director and the student-athlete's parents/guardians. The number ONE priority of the athletic trainer is the Health & Safety of the athlete.
- 3) If a "no-play" decision is in place the student athlete may be able to perform rehabilitation of the injury and is expected to report to the athletic training room daily for treatment and rehabilitation.
- 4) Medical Referral and Continued Care:
 - a) At the time of the comprehensive examination of the injury, the athletic trainer will present his/her opinion on the need of a medical referral.
 - b) Parents/guardian will be notified if there is a need for a medical referral.
 - i) ATC will give advice about the type of physician that would best help the student athlete.
 - ii) ATC will give advice about the specific physician that would best help the student athlete.
 - c) The final decision rests with the parent/guardian, if the parent/guardian disregards the referral the student athlete will be medically disqualified until they are seen by a physician.
 - d) If the student athlete receives care from a physician, then a completed form or Rx prescription will indicate the diagnosis and suggestions for the continued care of the student athlete, this note is required after seeing a physician. Should this documentation not be presented the athlete will be withheld from athletic participation until such time documentation is presented.
 - e) In the event an injured student athlete sees a physician without prior knowledge of the athletic trainer, the athlete must bring a written report of the physician's finding for the release to play. If this is not provided the student athlete will not be permitted to practice/compete until this note is filed with the athletic trainer.
 - f) Continued care of the student athlete is carried out in the form of daily reevaluation of the student athletes' progress, daily treatments, and rehabilitation
 - g) Where needed and available, such care is performed with periodic consultation of the attending physician.

General Return to Play Protocol

All student athletes who have sustained an injury must be cleared by the athletic trainer and/or physician to return to play. Regardless of clearance from a physician a student athlete wishing to return to play must also adhere to this protocol to return to play.

The following is a standard protocol for releasing a student athlete to return to play:

- 1) Student athlete must have little to no swelling within the injury site to be eligible to return to play
- 2) Student athlete must maintain full range of motion bilaterally to be eligible to return to play
- 3) Student athlete must maintain full strength bilaterally to be eligible to return to play
- 4) Student athlete must be pain free while performing functional aspects of their sports
- 5) Any student athlete needing extra support, taping, bracing, or padding must report to the ATR daily to receive such care as indicated and must maintain any equipment/bracing given to the athlete
- 6) Student athlete must understand the risks involved in returning to play after the injury and must be ready to adapt to the physical demands of their sport in relation to their injury
- 7) If the athletic trainer determines that continued play with injury is detrimental to the student athlete, regardless of physician clearance, student athlete will remain under no play/practice status until such time the athletic trainer can contact and consult with the physician to determine a return to play status.

Appendix 3: Pre-Participation Forms

Located at: https://www.bmhs.us/apps/pages/index.jsp?uREC_ID=297010&type=d&pREC_ID=691765

Self-Inspection Checklist

Rev. 8-19-17

FACILITY: _____ Date: ____/____/____

Indicate a Y (yes) or an N (no)

- _____ Is there a policy and procedures document for bloodborne pathogens and universal precautions regarding blood and other potentially infectious materials (OPIM) available?
- _____ Are adequate and appropriate personal protection equipment, spill clean-up kits/supplies and appropriately labeled sharps disposal containers, biohazard bags available?
- _____ Are all areas of the facility maintained in a clean orderly condition? (Good housekeeping practices?)
- _____ Are all exit signs requiring illumination provided same?
- _____ Are all exits provided appropriate and visible marking as exits?
- _____ Are all compressed gas (oxygen) bottles and cylinders secured to prevent them from falling over or from being knocked over?
- _____ Are suitable facilities for eye washing or body drenching within the proximity of activities or operations where there is a likelihood of splash, spray, or splatter of blood or other potentially infectious material?
- _____ Are fire extinguishers, alarms and hoses visually examined monthly to ensure proper function?
- _____ Are all fire extinguishers providing an annual maintenance check by a qualified person?
- _____ Are the wiring and components of the facility and its equipment free of hazards due to exposed live electrical parts?
- _____ Is the facility and equipment wiring adequately grounded?
- _____ Do modalities and electrical outlets undergo an annual inspection?
- _____ Are Material Safety Data Sheets (MSDS) for all hazardous materials properly maintained and readily accessible?
- _____ Does the employer provide adequate comprehensive training to all employees regarding exposure to hazardous materials?
- _____ Is emergency equipment such as AED's, AED pads, spine boards, splints etc. inspected on a routine basis and the Emergency Action Plan reviewed.
- _____ Are pharmaceuticals and medical files under lock and key?
- _____ Do outdoor hoses for water supply meet health and safety standards for safe drinking water?
- _____ Are water coolers and bottles sanitized and stored properly?
- _____ Are aisles, walkways, and passageways clear?
- _____ Is there clear line of sight always maintained to the treatment and rehabilitation areas in the athletic training room for supervising patients and all patients are directly always supervised.
- _____ Are medical records secure and locked in a filing cabinet or drawer so that all PHI is protected.

2.

- _____ Are floors and carpets free of slip-trip and fall hazards?

- _____ Is the “Slip-Trip & Falls” educational component reviewed?
- _____ Whirlpools are GFI equipped?
- _____ Are materials and/or equipment stored in such a way that sharp edges, etc. will not cause or harm or be of any interference?
- _____ Are supplies and materials stored in such a way as to not violate local Fire Codes?
- _____ Is lighting adequate?
- _____ Are emergency lighting systems adequate and inspected routinely?
- _____ Are stepladders in good condition and used properly?
- _____ Are there at least two fire exits, building evacuations clearly marked and exit doors the clearly marked?
- _____ All regulated waste, as defined by OSHA Bloodborne Pathogens Standard (1910.1030) discarded according to federal, state, and local regulations?
- _____ Are flammable and combustible liquids stored properly?
- _____ MSDS Sheets reviewed and checked accordingly?
- _____ Are sprinkler heads or smoke detectors free and clear and in working order?
- _____ Are extension cords used only temporary?
- _____ Is the heating and air system in good working order and routinely inspected?
- _____ Is the hot and cold-water supply of proper temperature needed in working order for whirlpool and the hot water is not of a scalding temperature?

Safety Issues Noted: _____

Corrective Actions Taken: _____

Name: _____ Title: _____

Signature: _____ Date: ____/____/____

Monthly AED Checklist

Rev. 1/11/18

High School: _____ Date: ____/____/____

AED Brand/Model: _____ AED Serial # _____

✓ Is the status indicator light green or flashing green? *(Pending brand could be different color)*

Yes () = Great! Your AED is working properly and does not need maintenance currently

No () = Contact support

✓ Is the AED "chirping or beeping"?

No () = Great! Your AED is working properly and does not need maintenance currently

Yes () = Contact support

✓ Are the pads (and backup pads if available) within expiration?

No () = Need to order replacement parts

Pad Expiration Date: ____/____/____

Yes () = Great!

✓ Is the battery (and backup battery if available) within expiration?

No () = Need to order replacement parts

Battery Expiration Date: ____/____/____

Yes () = Great!

✓ Is the AED visibly damaged?

Yes () = Contact support

No () = Great!

✓ Is the AED clear of debris and moisture?

Yes () = Great!

No () = Please remove the debris, dry the area and check that the AED's status indicator light is green and/or flashing green. If it is not flashing green, contact support

✓ Is the AED Supply Kit in good order? (If applicable)

Yes () = Great!

No () = Contact support

Supply Kit Expiration Date: ____/____/____

Other concerns or issues to be noted with the AED?

Check list completed by: _____ Date: ____/____/____

EMERGENCY PLANNING CHECKLIST – EAP

EMERGENCY ACTION PLAN GUIDELINES	Yes	No
1. Every school or organization that sponsors athletics should develop an EAP for managing serious and/or potentially life-threatening injuries. The development of a written EAP is the first step to making high school sports safer. It is important to ensure the EAP is clearly written and comprehensive enough to outline the exact steps to take place following a catastrophic injury.		
2. The EAP should be developed and coordinated with local EMS, school public safety officials on site medical personnel or school medical staff and school administrators. In the event of a catastrophic injury, all parties who may respond to the injury site should be included in the development of the plan.		
3. Every school should have a written EAP document distributed to all staff members. Coaches and other athletics staff members should be notified of the EAP steps and the location of the EAP. Additional distribution to event staff should be considered.		
4. The EAP should be specific to each venue and include maps and/or specific directions to that venue. Each venue that holds athletics practices, competitions or other school-sanctioned events should have their own EAP. The considerations per venue changes dramatically for items such as location of emergency equipment, EMS access to the injury location, and communication services.		
5. On site emergency equipment that may be needed in an emergency should be listed. Equipment such as automated external defibrillators (AEDs), cold-water immersion tubs, splint kits, and first aid supplies, should be outlined with their location in the EAP.		
6. The EAP should identify personnel and their responsibility to carry out the plan of action with a designated chain of command.		
7. Appropriate contact information for EMS should be clearly outlined in the EAP.		
8. Facility address, location, contact information etc. should be identified in the EAP with the venue specific information. (Google map attachment is a nice added touch when possible)		
9. Plan should specify documentation actions that need to be taken post emergency. Following an emergency, it is not atypical for institutions to have procedures that need to be documented. Each organization should include information that outlines what should take place after the emergency.		
10. EAP should be reviewed and rehearsed annually by all parties involved. Like distribution of the EAP, the EAP should be rehearsed by those parties involved.		
11. Healthcare professionals who will provide medical coverage during games, practices, or other events should be included. Athletic trainers, or other properly trained healthcare professionals should be included in the development and implementation of the EAP.		
12. The EAP is posted at each venue site for athletics (game and practice sites).		

Bishop McGuinness High School Emergency Action Policies Handbook

1725 Highway 66S Kernersville, NC 27284 336-564-1010

Last Revised July 2018

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5. Resources

Bishop McGuinness High School Emergency Action Plan

EMERGENCY CONTACT NUMBERS

Head Athletic Trainer (Brittany Price) (336) 564-1010 ext 1257

Athletic Director (Jeff Stoller (336) 707-3252)

Assistant Athletic Director (Mark Holcomb) 336-470-1590

HEALTH CARE TEAM Brittany Price, Head Athletic Trainer; Brian Smith First Responder ;Dr. Chris Brumfield, Orthopedic Physician

Introduction

Emergency situations may arise at any time during athletic events. Expedient action must be taken to provide the best possible care to the athletes of emergency and/or life-threatening conditions. The development and implementation of an emergency plan will help ensure that the best care will be provided. Athletic departments have a duty to develop an emergency

plan that may be implemented immediately when necessary and to provide appropriate standards of health 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 plan, proper coverage of events, maintenance of appropriate emergency equipment and supplies, utilization of appropriate emergency medical personnel, and continuing education in emergency management. Hopefully, through careful pre-participation physical screening, 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 will enable each emergency to be managed appropriately.

Components of the Emergency Plan

There are three basic components of this plan:

1. Emergency personnel
2. Emergency communication
3. Emergency equipment

Emergency Plan Personnel

With athletic association practice and competition, the first responder to an emergency is typically a member of the sports medicine staff, most commonly a certified athletic trainer, adult first responder, student assistant, or coach. A team physician may not be present at every organized practice or competition. 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. The first responder in some instances may be a coach or other institutional personnel. Certification in cardiopulmonary resuscitation (CPR), first aid, prevention of disease transmission, and emergency plan review is required for all athletics personnel associated with practices, competitions, skills instruction, and strength and conditioning.

The development of an emergency plan cannot be complete without the formation of an emergency team. The emergency team may consist of several healthcare providers including physicians, emergency medical technicians, certified athletic trainers; adult first responders; student assistants; coaches; managers; and possibly 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, or the preference of the head athletic trainer. There are four basic roles within the emergency team. The first and most important role is immediate care of the athlete. The most qualified individual on the scene should provide acute care in an emergency situation. Individuals with lower credentials should yield to those with more appropriate training. The second 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 assistants, managers, and coaches are good choices for this role. The third 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. After EMS has been activated, the fourth role in the emergency team should be performed, directing EMS to the scene. One member of the team should be responsible for meeting first responders such as firemen or rescue squad personnel as they arrive at the site of the contest and a second person should direct Paramedics. 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 assistant, manager, or coach may be appropriate for this role.

Roles within the Emergency Team

1. Immediate care of the athlete
2. Emergency equipment retrieval
3. Activation of the Emergency Medical System
4. Direction of EMS to scene

Activating the EMS System

1. Making the Call
 - a. 911 (if available)

- b. Telephone number for local police, fire department, and ambulance service
- 2. Providing Information
 - a. Name and telephone number of caller, address of the emergency
 - b. Number of athletes
 - c. Condition of athletes
- 3. First aid treatment initiated by the athletic trainer/first responder
 - a. Specific directions needed to locate the emergency scene (“come to south entrance of coliseum”)
 - b. 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 delivery of emergency care in athletic trauma situations. Athletic trainers and emergency medical personnel must work together to provide the best possible care to injured athletes. Communication prior to the event is a good way to establish boundaries and to build rapport between both groups of professionals. Prior to the beginning of each fall season athletic trainers and Fire rescuer/EMTs will meet to coordinate communication and emergency response plans, as designated by BMHS Athletic Training Program. If emergency medical transportation is not available on-site during a sporting event then direct communication with 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. A cellular phone is preferred, if available. At any athletic venue, whether home or away, it is important to know the location of a workable telephone. Prearranged 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 available should be appropriate for the level of training for the emergency medical providers. 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 arises.

Transportation

Emphasis is placed on having an ambulance on site at high-risk sporting events. EMS response time is additionally factored in when determining on site ambulance coverage. The athletics director coordinates on site ambulance for competition in home football games when available. Ambulances may be coordinated on site for other special events/sports, such as major tournaments or NCHSAA regional or championship events. Consideration is given to the capabilities of transportation service available and the equipment and level of trained personnel on board the ambulance. If 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. In the emergency evaluation, the primary survey assists the emergency care provider in identifying emergencies requiring critical intervention and in determining transport decisions. In an emergency, 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 leaves the site in transporting the athlete

Crowd Control

While this is not listed as one of the four roles of emergency responders, this is critical to successful emergency management. It is necessary to decide beforehand what administrator, teacher, or other personnel will be responsible for keeping the public, spectators, or crowd away from the scene. This will help keep the scene calm and allow those responding to the athlete/patient to work efficiently.

Conclusion

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

Approved by:

Principal _____ Date: _____

Athletic Director _____ Date: _____

Certified Athletic Trainer _____ Date: _____

First Responder _____ Date: _____

Team Physician _____ Date: _____

Team Physician _____ Date: _____

Baseball field

Emergency Personnel

- Team physicians (when applicable), Athletic Trainers, first responders, coaches, administrators.

Emergency Communication

- Brittany Price, Athletic Trainer
- Brian Smith, First Responder
- Jeff Stoller, Athletic Director
- Mark Holcomb, Asst. Athletic Director, Head Football Coach
- Head of School, Dr. Jared Rashford
- Phone line to the main office 336.564.1010

Emergency Equipment

- Basic first aid kit including tools for extraction of equipment, AED.

Roles of the First Responders

1) Immediate care of the injured athlete or ill student (Most qualified at the scene shall assume this role).

2) Emergency equipment retrieval – Athletic Trainer, coaches, available personnel.

3) Activation of EMS – Physician, Athletic Trainer, student, coach, or administrator.

a. 911 call (provide name, address, telephone number; number of individuals injured; condition of injured; first aid treatment; specific directions; other information as requested).

b. Emergency Phone Numbers: (Dial 9 for outside line if using school phone)

- EMS, Fire, Police: 911
- Poison Control Center: 1-800-222-1222
- Urgent Care: Moses Cone Urgent Care: (336) 993-6120
- c. Information for Emergency Call:
 - Location: Bishop McGuinness High School
 - Street Address: 1725 NC Hwy 66 South Kernersville, NC
 - Caller's Name?
 - What happened?
 - How many people are injured?
 - Condition of injured person(s)?
 - Help being provided **Notify parents as soon as possible (Consent papers, have parent contact numbers).

4) Directions for EMS to get to scene:

- a. Enter open gates at top of field entrance at north parking lot.
- b. Designate one or two coaches to "flag down" EMS and direct to scene.
- c. Scene control: limit scene to first aid providers and move bystanders away from area.

Cafeteria (Wrestling and Cheerleading)

Emergency Personnel

- Team physicians (when applicable), Athletic Trainers, first responders, coaches, administrators.

Emergency Communication

- Brittany Price, Athletic Trainer
- Brian Smith, First Responder
- Jeff Stoller, Athletic Director
- Mark Holcomb, Asst. Athletic Director, Head Football Coach
- Head of School, Dr. Jared Rashford
- Phone line to the main office 336.564.1010

Emergency Equipment

- Basic first aid kit including tools for extraction of equipment, AED.

Roles of the First Responders:

- 1) Immediate care of the injured athlete or ill student (Most qualified at the scene shall assume this role).
- 2) Emergency equipment retrieval – Athletic Trainer, coaches, available personnel.
- 3) Activation of EMS – Physician, Athletic Trainer, student, coach, or administrator.

a. 911 call (provide name, address, telephone number; number of individuals injured; condition of injured; first aid treatment; specific directions; other information as requested).

b. Emergency Phone Numbers: (Dial 9 for outside line if using school phone)

- EMS, Fire, Police: 911
- Poison Control Center: 1-800-222-1222
- Urgent Care: Moses Cone Urgent Care: (336) 993-6120
- c. Information for Emergency Call:
 - Location: Bishop McGuinness High School
 - Street Address: 1725 NC Hwy 66 South Kernersville, NC
 - Caller's Name?
 - What happened?
 - How many people are injured?
 - Condition of injured person(s)?
 - Help being provided **Notify parents as soon as possible (Consent papers, have parent contact numbers).

4) Directions for EMS to get to scene:

- a. Turn into south parking lot just behind school. Enter back doors of cafeteria.
- b. Designate one or two coaches to "flag down" EMS and direct to scene.
- c. Scene control: limit scene to first aid providers and move bystanders away from area.

Football Stadium (Football, Soccer, Lacrosse, Track and Field)

Emergency Personnel

- Team physicians (when applicable), Athletic Trainers, first responders, coaches, administrators.

Emergency Communication

- Brittany Price, Athletic Trainer
- Brian Smith, First Responder
- Jeff Stoller, Athletic Director
- Mark Holcomb, Asst. Athletic Director, Head Football Coach
- Head of School, Dr. Jared Rashford
- Phone line to the main office 336.564.1010

Emergency Equipment

- Basic first aid kit including tools for extraction of equipment, AED.

Roles of the First Responders:

- 1) Immediate care of the injured athlete or ill student (Most qualified at the scene shall assume this role).
- 2) Emergency equipment retrieval – Athletic Trainer, coaches, available personnel.
- 3) Activation of EMS – Physician, Athletic Trainer, student, coach, or administrator.

a. 911 call (provide name, address, telephone number; number of individuals injured; condition of injured; first aid treatment; specific directions; other information as requested).

b. Emergency Phone Numbers: (Dial 9 for outside line if using school phone)

- EMS, Fire, Police: 911
 - Poison Control Center: 1-800-222-1222
 - Urgent Care: Moses Cone Urgent Care: (336) 993-6120
- c. Information for Emergency Call:
- Location: Bishop McGuinness High School
 - Street Address: 1725 NC Hwy 66 South Kernersville, NC
 - Caller's Name?
 - What happened?
 - How many people are injured?
 - Condition of injured person(s)?
 - Help being provided **Notify parents as soon as possible (Consent papers, have parent contact numbers).
- 4) Directions for EMS to get to scene:
 - a. Enter open gates at top of field entrance at north parking lot.
 - b. Designate one or two coaches to "flag down" EMS and direct to scene.
 - c. Scene control: limit scene to first aid providers and move bystanders away from area.

Gymnasium

Emergency Personnel

- Team physicians (when applicable), Athletic Trainers, first responders, coaches, administrators.

Emergency Communication

- Brittany Price, Athletic Trainer
- Brian Smith, First Responder
- Jeff Stoller, Athletic Director
- Mark Holcomb, Asst. Athletic Director, Head Football Coach
- Head of School, Dr. Jared Rashford
- Phone line to the main office 336.564.1010

Emergency Equipment

- Basic first aid kit including tools for extraction of equipment, AED.

Roles of the First Responders:

- 1) Immediate care of the injured athlete or ill student (Most qualified at the scene shall assume this role).
- 2) Emergency equipment retrieval – Athletic Trainer, coaches, available personnel.
- 3) Activation of EMS – Physician, Athletic Trainer, student, coach, or administrator.

a. 911 call (provide name, address, telephone number; number of individuals injured; condition of injured; first aid treatment; specific directions; other information as requested).

b. Emergency Phone Numbers: (Dial 9 for outside line if using school phone)

- EMS, Fire, Police: 911
- Poison Control Center: 1-800-222-1222
- Urgent Care: Moses Cone Urgent Care: (336) 993-6120
- c. Information for Emergency Call:
 - Location: Bishop McGuinness High School
 - Street Address: 1725 NC Hwy 66 South Kernersville, NC
 - Caller's Name?
 - What happened?
 - How many people are injured?
 - Condition of injured person(s)?
 - Help being provided **Notify parents as soon as possible (Consent papers, have parent contact numbers).

4) Directions for EMS to get to scene:

- a. Turn into north parking lot and enter side doors of gym.
- b. Designate one or two coaches to "flag down" EMS and direct to scene.
- c. Scene control: limit scene to first aid providers and move bystanders away from area.

Softball field

Emergency Personnel

- Team physicians (when applicable), Athletic Trainers, first responders, coaches, administrators.

Emergency Communication

- Brittany Price, Athletic Trainer
- Brian Smith, First Responder
- Jeff Stoller, Athletic Director
- Mark Holcomb, Asst. Athletic Director, Head Football Coach
- Head of School, Dr. Jared Rashford
- Phone line to the main office 336.564.1010

Emergency Equipment

- Basic first aid kit including tools for extraction of equipment, AED.

Roles of the First Responders:

- 1) Immediate care of the injured athlete or ill student (Most qualified at the scene shall assume this role).
- 2) Emergency equipment retrieval – Athletic Trainer, coaches, available personnel.
- 3) Activation of EMS – Physician, Athletic Trainer, student, coach, or administrator.

a. 911 call (provide name, address, telephone number; number of individuals injured; condition of injured; first aid treatment; specific directions; other information as requested).

b. Emergency Phone Numbers: (Dial 9 for outside line if using school phone)

- EMS, Fire, Police: 911
- Poison Control Center: 1-800-222-1222
- Urgent Care: Moses Cone Urgent Care: (336) 993-6120
- c. Information for Emergency Call:
 - Location: Bishop McGuinness High School
 - Street Address: 1725 NC Hwy 66 South Kernersville, NC
 - Caller's Name?
 - What happened?
 - How many people are injured?
 - Condition of injured person(s)?
 - Help being provided **Notify parents as soon as possible (Consent papers, have parent contact numbers).

4) Directions for EMS to get to scene:

- a. Enter open gates at top of field entrance at north parking lot, follow gravel road to last field on left.
- b. Designate one or two coaches to "flag down" EMS and direct to scene.
- c. Scene control: limit scene to first aid providers and move bystanders away from area.

Inclement Weather Policies

Hot Weather Guidelines (From NATA Fluid Replacement Statement and NCHSAA Health and Safety guidelines)

Dehydration can compromise athletic performance and increase the risk of exertional heat injury. Athletes do not voluntarily drink sufficient water to prevent dehydration during physical activity. Drinking behavior can be modified by education, increasing fluid accessibility, and optimizing palatability. However, excessive overdrinking should be avoided because it can also compromise physical performance and health. We will practical guidelines regarding fluid replacement for athletes.

- Most of the heat related issues occur during the first week of practices/training, therefore acclimatization is key
- Acclimatization will take place over 11 days
- Gradually introduce additional equipment
- Begin with less intensive/shorter practices and gradually increase intensity and time
- Unlimited amounts of water will be made readily available
- It is recommended that 6-10oz of water be consumed every 20 minutes
- Wet bulb temperatures will be taken to determine training standards using a sling psychrometer or equivalent device if available (See table).
- A 3 percent dehydration rule will be in effect using a weight chart to monitor athletes during the acclimatization period.

Acclimatization (Football)

- Days 1–5 are the first formal practices. No more than 1 practice occurs per day.
- Total practice time should not exceed 3 hours in any 1 day.
- 1-hour maximum walk-through is permitted on days 1–5, however there must be a minimum 3-hour break in a cool environment between practice and walk-through (or vice versa).
- During days 1–2 of first formal practices, a helmet should be the only protective equipment permitted (if applicable). During days 3–5, only helmets and shoulder pads should be worn (if applicable). Beginning on day 6, all protective equipment may be worn and full contact may begin.

*Football only: on days 3–5, contact with blocking sleds and tackling dummies may be initiated.

*Full-contact sports: 100% live action drills should begin no earlier than day 6.

- Day 6–14, double-practice days must be followed by a single-practice day. On single- practice days, 1 walk-through is permitted, separated from the practice by at least 3 hours of continuous rest. When a double-practice day is followed by a rest day, another double practice day is permitted after the rest day.
- On a double-practice day, neither practice day should exceed 3 hours in duration, and no more than 5 total hours of practice in the day. During the 2-hour practice, there can be NO live action. Warm-up, stretching, cool-down, walk-through, conditioning and weight-room activities are included as part of the practice time. The 2 practices should be separated by at least 3 continuous hours in a cool environment.
- Because the risk of exertional heat illnesses during the preseason heat-acclimatization period is high, we strongly recommend that an athletic trainer be on site before, during and after all practices. (Adapted from Korey Stringer Institute, 2015)

According to NCHSAA requirements and NATA suggestions, Wet Bulb Global Temperature (WBGT) should be monitored during practices to determine the necessary adjustments to be made at practices during hot and humid weather. WBGT considers the combined effects of air temperature, humidity, and solar radiation on the human body. WBGT should be measured (Using a scientifically approved device) for all sports when student- athletes may be at risk for exertional heat illness (EHI). WBGT should be accessed every hour beginning 30 minutes before the beginning of practice.

Wet Bulb Global Temperature Guidelines

WBGT Index (F) Athletic Activity Guidelines Less than 80 Unlimited activities with primary cautions for new or unconditioned athletes or extreme exertion; schedule mandatory rest/water breaks (5 min water/rest break every 30 min) 80-84.9 Normal practice for athletes; closely monitor new or unconditioned athletes and all athletes during extreme exertion. Schedule mandatory rest/water breaks. (5 min water/rest break every 25 min) 85-87.9 New or unconditioned athletes should have reduced intensity practice and modifications in clothing. Well-conditioned athletes should have more frequent rest breaks and hydration as well as

cautious monitoring for symptoms of heat illness. Schedule frequent mandatory rest/water breaks. (5 min water/rest break every 20 min) Have cold or ice immersion pool on site for practice. 88-89.9 All athletes must be under constant observation and supervision. Remove pads and equipment. Schedule frequent mandatory rest/water breaks. (5 min water/rest break every 15 min) Have cold or ice immersion pool on site for practice. 90 and/or above SUSPEND PRACTICE/MUST INCLUDE MANDATORY BREAKS AS DIRECTED BY GAMEDAY ADMINISTRATOR DURING CONTEST.

Recognition of Heat Illness:

- Heat Exhaustion signs and symptoms may occur as follows: extreme weakness, dehydration, coordination problems, syncope, profuse sweating, paleness, headache, muscle cramps, vomiting
- Heat Stroke signs and symptoms may occur as follows: elevated core temperature 104 F or above, CNS dysfunction (collapse, aggressiveness, confusion, altered consciousness) hyperventilation, dizziness, vomiting, diarrhea, weakness, dry mouth, muscle cramps

o Heat Stroke is a MEDICAL EMERGENCY. Contact EMS (911) if you suspect an athlete is experiencing a heat stroke o Due to the body's inability to control the body temperature and it becomes overheated.

❖ Management of Heat Illness:

- Primary goal is to reduce body temperature!
- o Remove excessive clothing and equipment to Immerse athlete in cold tub
- If cold immerse tub is not available other options include:
 - Cold ice towels
 - Use cooler of waters
 - Ice chest
 - Ice bags – place at head, neck, armpits, under knees, and groin
 - Move to air-conditioned area
- Keep athlete is immerse cold tub until shriving. o Monitor vital signs o If you suspect a heat stroke and/or athlete is

not improving, call 911 and follow EAP

Cold Weather Guidelines

Each school will default to practice/game restrictions put in place by BMHS. If no such restriction is in place for the day, follow the procedure below:

Temperature Procedure 30°F-26°F Be aware of the potential for cold injury and notify appropriate personnel of the potential. 25°F-16°F Provide additional protective clothing, cover as much exposed skin as practical, and provide opportunities and facilities for re-warming 15°F-1°F Consider modifying activities to limit exposure or to allow more frequent chances to re-warm 0°F and below Consider terminating or rescheduling activity.

Lightning Policy (From the NATA Position Statement on Lightning Safety)

Lightning is the most dangerous and frequently encountered thunderstorm hazard that people experience every year. Over the past century, it has consistently been in the top 2 causes of storm-related deaths in the United States. During the most recent decade, lightning was responsible for an average of 42 fatalities yearly in the United States and an estimated 10 times as many injuries. Lightning is a widespread danger to the physically active population, in part because of the prevalence of afternoon to early evening thunderstorms from late spring to early fall and a societal trend toward outdoor physical activities during those times. On average, 25 million lightning-flashes strike the ground each year in the United States. Education regarding lightning danger and precautions to lessen the likelihood of being struck by lightning are critical to reducing casualties. All individuals, particularly leaders in athletics and recreational activities, should appreciate the lightning hazard, learn the published lightning-safety guidelines, act prudently, and encourage safe behavior in others. Each person should also ensure his or her own safety when a lightning hazard is present.

NATA also suggests establishing an EAP specific to lightning. The EAP should include several components including:

1. Promoting lightning safety slogans
2. Establishing a chain of command
3. Use a reliable means of monitoring the weather
4. Identify safe locations from lightning hazards
5. Establish a specific criterion to suspend and resume activity

Recommendations

The National Athletic Trainers' Association (NATA), NCHSAA, and BMHS recommend a proactive approach to

lightning safety, including the implementation of a lightning-safety policy that identifies safe locations for shelter from lightning hazard. Further components include monitoring the weather and establishing a chain of command to determine when it is safe to continue playing or stop activity and move to a safe location. This person must have recognized and unchallengeable authority to suspend activity when thunder is heard or a cloud-to-ground lightning bolt is seen, the thunderstorm is close enough to strike your location with lightning. Suspend play for thirty minutes and take shelter immediately.

Per recommendations of NATA and NCHSAA, BMHS will follow the thirty-minute rule which states: 1. When thunder is heard or a cloud-to-ground lightning bolt is seen, the leading edge of the thunderstorm is close enough to strike your location with lightning. Suspend play for thirty (30) minutes and take shelter immediately. 2. Once play has been suspended, wait at least 30 minutes after the last thunder is heard or flash of lightning is witnessed prior to resuming play. 3. Any subsequent thunder or lightning after the beginning of the 30-minute count will reset the clock and another 30-minute count should begin.

If lightning is detected in the area, athletes, coaches, and all spectators should seek safe shelter. Individuals should avoid seeking shelter under trees, in open fields, around bodies of water, and avoid the use of landline telephones during thunderstorms. If an individual has suffered from a lightning strike injury, qualified personnel should monitor vital signs and if deemed necessary perform CPR until EMS arrives.

Safe locations during lightning and thunderstorms are as follows:

1. Main gym 2. Locker rooms 3. Athletic building 4. Car

First aid to be given to lightning strike victims:

1. Check the scene for safety 2. Activate EMS (911) 3. If necessary, move lightning victim to a safe location 4. Evaluate airway, breathing, and circulation 5. Begin CPR if necessary 6. Monitor vital signs 7. Check for burns, fractures, shock, and/or hypothermia.

Outline of BMHS guidelines:

1. Game officials, Athletic Director, Assistant Athletic Director, Principal, Assistant Principal, Athletic Trainer, or Game Day Coordinator will make official call to remove individuals from the practice/game field. Coaches and Athletic Trainer will call to remove individuals from the practice/game field. 2. We will follow the thirty-minute as outlined by NCHSAA 3. The Athletic Trainer and/or Assistant Coach will be the weather watchers and monitor when it is safe to return 4. The Athletic Trainer, Athletic Director, and/or Assistant Athletic Director will monitor the weather on weather.com or the local weather forecast 5. Activity will resume when deemed safe by the Athletic Trainer, Athletic Director, and/or Assistant Athletic Director.

Tornado Policy

In the event of a tornado warning or watch, please make sure to confirm with school administration and athletic directors about the course of action for your athletes. These violent storms can arise at any time during a favorable event and being caught off guard could be deadly. Please make sure your coaches and athletes are aware of the safe locations to report to in the event of tornado activity. If there is not a school policy regarding a safe location, please get your athletes to an interior room of a sturdy building. This is best decided prior to a severe weather event.

Additional Considerations for Specific Conditions

Catastrophic Brain (including Concussions) and Neck Injuries

A catastrophic injury is a severe injury to the spine, spinal cord, or brain and may also include skull or spinal fractures. The National Center for Catastrophic Sport Injury Research in the United States classifies catastrophic injuries based on the three outcomes associated with them: fatality, those causing permanent severe functional disability, and those causing severe head or neck trauma with no permanent disability. A fatal injury may be a direct result of trauma sustained during an activity, or may occur indirectly.

Recommendations for Care (per NATA statement on care of cervical spine injuries):

1. Prevention

a. Individuals responsible for emergency care of athletes should be familiar with safety rules enacted to prevent brain, neck, and spine injuries. b. Individuals responsible for emergency care of athletes should be familiar with the recommendations of manufacturers for equipment maintenance, fitting, and removal. c. Individuals responsible for emergency care of athletes should educate athletes and coaches about mechanisms of catastrophic brain and neck injuries, dangers of head-down contact, and prevention of catastrophic brain and neck injuries

2. Planning and Rehearsing

a. Individuals responsible for the emergency care of athletes (including Athletic Trainers, EMS, and Fire Rescue associated with the school, and Team Physicians) should review and rehearse/discuss the EAP for the school and how to manage a catastrophic brain and neck injury at the BMHS

i. Includes discussion of equipment removal (helmet and shoulder pads) and transportation of the athlete in the event of a catastrophic brain and/or neck injury
b. All individuals responsible for the emergency care of the athletes (including Athletic Trainers, EMS, and Fire Rescue associated with the school, and Team Physicians) should practice the EAP for the school in the event of a catastrophic brain and/or neck injury

ii. Appoint an individual in charge of neck stabilization, equipment removal, retrieval, and use of emergency equipment, and transferring athlete

In the event of a catastrophic brain and/or neck injury the individuals responsible for the emergency care of athletes will act accordingly:

1. Activate EAP

2. Administer necessary care to injured athlete

a. The facemask will be removed from the helmet to monitor airway and provide care if airway is compromised

b. Athletic Trainer and/or most qualified personnel will stabilize the neck and direct care

c. Once EMS arrives, injured athlete will be transferred to a spine board

i. Preferred method of movement is the 6-8-man lift

d. Once on spine board, patient will be transferred to an EMS gurney/bed

e. Once transferred to an EMS gurney/bed, before transferring athlete to the hospital, equipment will be removed (helmet and shoulder pads)

f. Patient will then be transferred. Designated personnel (Athletic Trainer, Athletic Director, Coach, Parent) will accompany injured athlete to the hospital.

Care for Catastrophic Brain and/or Neck injuries should be reviewed yearly with all individuals responsible for the emergency care of athletes (including, but not limited to Athletic Trainer, EMS and Fire Rescue associated with the school, and Team Physicians).

Sudden Cardiac Arrest (SCA)

Cardiac arrest, also known as cardiopulmonary arrest or circulatory arrest, is the cessation of normal circulation of the blood due to failure of the heart to contract effectively.

Recommendations for Prevention and Care:

1. All athletes should have a pre-participation physical exam. If the physician identifies any cardiovascular symptoms and/or abnormalities, the athlete must be cleared by a cardiologist.

a. Some symptoms may include, but are not limited to:

i. Exertional chest pain, exertional syncope, palpitations, exertional shortness of breath, or exertional fatigue

b. The athlete must provide a doctor's note from cardiologist clearing them to participate in sports.

2. AED's and CPR

a. An automated external defibrillator (AED) should be on-site and readily available within three minutes (with one minute being ideal) for all organized sports activities.

b. School staff, medical professionals, coaches, and athletes should be educated annually about location and use of AEDs.

c. AED will undergo maintenance regularly – battery and pads checked.

d. Athletic Trainer(s), Athletic Director, Coaches, and Game Managers will have regular, up-to date CPR and AED training.

3. Any athlete who has collapsed and is unresponsive should be assumed to be in SCA until proven otherwise. Proper management includes:

- a. Prompt recognition of SCA. Brief seizure-like activity occurs in 50 percent of young athletes with SCA and should not be mistaken for a seizure.
- b. Early activation of the EMS system (call 9-1-1)
- c. Early CPR beginning with chest compressions, use of an AED
- d. Transport of the patient with SCA to a hospital capable of advanced cardiac care.

Asthma

According to the NATA Position Statement on Asthma, asthma is defined as a chronic inflammatory disorder of the airways characterized by variable airway obstruction and bronchial hyperresponsiveness. Airway obstruction can lead to recurrent episodes of wheezing, breathlessness, chest tightness, and coughing, particularly at night or in the early morning. Asthma can be triggered by many stimuli, including allergens (e.g., pollen, dust mites, animal dander), pollutants (e.g., carbon dioxide, smoke, ozone), respiratory infections, aspirin, nonsteroidal anti-inflammatory drugs (NSAIDs), inhaled irritants (e.g., cigarette smoke, household cleaning fumes, chlorine in a swimming pool), particulate exposure (e.g., ambient air pollutants, ice rink pollution), and exposure to cold and exercise. Airflow limitation is often reversible, but as asthma symptoms continue, patients may develop “airway remodeling” that leads to chronic irreversible airway obstruction. Severe attacks of asthma can also cause irreversible airflow obstruction that can lead to death.

Recommendations for Recognition, Prevention, and Care:

1. All athletes must have pre-participation screening which should consist of identification of any respiratory issues, including asthma.
2. Athletic Trainers and First Responders should be educated on signs and symptoms associated with asthma, including:
 - a) Chest tightness b) Coughing c) Prolonged shortness of breath d) Wheezing e) Inability to catch one’s breath f) Physical activities affected by breathing difficulty g) Breathing difficulty when exposed to certain allergens or irritants h) An athlete who is conditionally well but unable to perform as well as athletes without asthma i) Family history of asthma
3. If an athlete is suspected to have asthma, athlete should be referred to their primary care physician and/or team physician for further evaluation.
 - a) The evaluation made by the team doctor should include pulmonary function testing.
4. Management and Care of Asthma
 - a. Athletic Trainers should be educated on proper management and care of asthmatic athletes. Athletes with exercise-induced asthma (EIA) may benefit from use of short and long-acting β_2 -agonists.
 - b. When used to prevent EIA, a short-acting β_2 -agonist, such as albuterol, should be inhaled 10 to 15 minutes prior to exercise.
 - c. The excessive need for short-acting β_2 -agonists therapy during practice or an athletic event should cause concern. A physician should evaluate the athlete before returning to participation.
 - d. All athletes with asthma should have their rescue inhaler readily available to them at practices, conditioning sessions, and games.
 - e. Athletes should be educated on when they should use their inhaler and how to properly use it.
 - f. If available, Athletic Trainers should have an extra rescue inhaler available for emergency situations.
 - g. Athletes should have access to alternate training sites (i.e., indoor vs. outdoor) during situations in which they may be triggered for an asthma attack when practical.
 - h. Athletes should have regular check-ups to manage changes in asthma.
 - i. If an athlete experiences any degree of respiratory distress, they should stop activity and be rapidly referred to their physician and/or ER.

Blood Borne Pathogens

BMHS will follow the guidelines and recommendations of the NCHSAA and CDC when dealing with Bloodborne Pathogens.

1. CDC recommendations:
 - a. Barrier precautions should be routinely used to prevent skin and mucous-membrane exposure with blood or other bodily fluids.

b. Gloves will be available in the BMHS Athletic Training Room. Also, there will be gloves located in the Athletic Trainer kit(s) and any kit(s) provided to the teams. b. Gloves should be worn when handling items, cleaning surfaces, and/or body parts exposed to blood or bodily fluids. (1) Examples include: any open wound, blister, ingrown toenail, changing dressings, suture care or removal, contact with the mouth, and cleansing of the mats or any athletic surface

c. Mouth-to-mouth protection will be stored in the Athletic Training Room and/or Athletic Training Kit d. Biohazard containers and/or bags will be available in the Athletic Training Room and/or Athletic Training Kits for proper disposal of items soiled by bodily fluids and blood.

d. Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or bodily fluids. Hands should be washed immediately after gloves are removed.

e. Hand soap and water is readily available in the men's/women's locker-rooms and bathrooms. Antibacterial sanitizer and/or wipes will be available in the Athletic Training Room and/or Athletic Training Kits

f. Surfaces contaminated with blood should be cleaned with any OSHA approved disinfectant solution.

g. Athletic Trainers will clean any surfaces contaminated with blood and/or bodily fluids immediately following care of that individual. In addition, the Athletic Trainer will clean the tables and tabletop surfaces daily.

h. Precautions should be taken to prevent injuries caused by needles, scalpels and other sharp instruments or devices. To prevent needle-stick injuries, needles should not be recapped, purposely bent, or broken by hand, removed from disposable syringes, or otherwise manipulated by the hand. Any sharps will be kept in a secured location in the Athletic Training Room and/or the Athletic Training kit if necessary.

2. NCHSAA recommendations:

a) Bleeding must be stopped immediately, and all wounds covered. All blood-soaked clothing must be removed before continuing competition or practice. Contaminated clothing must be cleaned before using again.

b) Athletic trainers or caregivers need to wear gloves and take other precautions to prevent blood-splash from contaminating themselves or others. Immediately wash contaminated skin or mucous membranes with soap and water.

c) Clean all contaminated surfaces and equipment with disinfectant before returning to competition. Be sure to use gloves with cleaning.

d) Any blood exposure or bites to the skin that break the surface must be reported and evaluated by a medical provider immediately.

3. In addition, Athletic Trainers, Coaches, Athletic Director, and Assistant Athletic Directors should encourage athletes to follow universal hygiene guidelines such as:

a) Shower immediately following practices, conditioning, and games with warm soap and water

b) Wash all workout clothing after practices and games

c) Wash all equipment and gear worn at practices frequently

d) Don't share personal hygiene products (i.e., razors) and/or towels with other players

e) Let your Athletic Trainer and/or health professional of any abnormal lesions, cuts, or open wounds.

Skin Diseases

Skin infections are common in athletes due to various reasons including poor hygiene practices, close quarters shared by athletes, and trauma. Therefore, guidelines should be established to try to decrease the spread of skin diseases. BMHS will follow several guidelines based on recommendations established by NCHSAA and NATA.

Recommendations for Prevention, Management, and Care:

1. Athletic Training Room(s), locker rooms, and athletic facilities will maintain a clean environment.

a) Important surfaces to clean daily include, but are not limited to: Athletic Training Room treatment tables, benches, and wrestling mats.

b) Disinfectants should be approved by the EPA.

2. Athletic Trainers, First Responders, any health care professionals, Athletic Directors, Assistant Athletic Directors, Coaches, and any athletes will practice good hygiene practices.

a) Athletes should shower after practices and competitions

b) Athletes should avoid sharing towels, equipment, practice gear, clothing, and razors

- c) Athletes with open wounds should avoid using whirlpools and/or ice buckets/tubs.
- d) All wounds should be covered during practices, conditioning, and competitions
- e) Athletes should be encouraged to report any open wounds

3. Athletic Trainers and health care professionals should be educated on skin diseases and educate athletes and coaches on skin diseases.

a) Athletic Trainers should be educated on the recognition, proper treatment, and management, and return to play policies of common skin diseases

i. Examples of skin diseases include Fungal (Tinea capitis, Tinea corporis), Viral (Herpes simplex, Molluscum contagiosum), Bacterial (Impetigo, Folliculitis, MRSA)

4. Management and care

a) If an athlete has a questionable lesion, parents/guardians, Athletic Trainers, and Coaches should be notified about lesion. Athlete may not return until evaluated and cleared by physician.

b) If an outbreak occurs, team members should be checked for lesions also. Athletic Directors and Coaches should also be notified.

c) All open wounds will be covered during competitions.

Exertional Sickling

Exertional sickling is a medical emergency occurring in athletes carrying the sickle cell trait. When an exertional sickling episode occurs, the red blood cells change shape or “sickle” this causes those cells to clump in small blood vessels, leading to decreased blood flow. The drop in blood flow and oxygen delivery leads to a breakdown of muscle tissue and cell death, known as fulminant rhabdomyolysis.

Athletes with sickle cell trait may still participate in sports, but proper education and precautions should be taken place with practices, conditioning, and competitions. The athletes with sickle cell trait, guardians/parents, Athletic Director, Assistant Athletic Directors, First Responders, and Coaches should be educated about exertional sickling, the signs, and symptoms, and precautions to take with athletes with sickle cell trait. Some factors that may increase risk for and worsen complications for exertional sickling are heat, dehydration, altitude, and asthma.

Exertional sickling is commonly mistaken for a heat illness or cardiac collapse. However, there are several differentials symptoms that help identify exertional sickling as compared to heat illness and cardiac collapse.

Symptoms to look for with exertional sickling:

1. Timing: sickling usually occurs within the first 30 minutes of practice, possibly during initial sprints, as compared to heat illness which may take longer to occur
2. Sickling players will usually slump to the ground due to muscle weakness as compared to heat illness cramps where muscles lock up
3. Athletes may complain of feeling like they “can’t go on” at practice
4. Athletes may experience low back pain, muscle pain, fatigue, and weakness

Precautions to take with athletes with sickle cell trait:

1. Efforts to obtain newborn screening results of sickle cell trait (SCT) status during the pre-participation physical are recommended. In the absence of these results, SCT screening should be considered for all athletes performing intense activity, with football being the highest risk sport for athletes with sickle cell trait. No patient who has SCT should be denied sports participation.
2. All personnel, including Athletic Trainers, First Responders, Athletic Directors, and Coaches, should be educated on sickle cell trait and the signs and symptoms of exertional sickling.
3. Precautions should be taken with athletes with sickle cell trait.
 - a. Slow, gradual progression of preseason conditioning regimen
 - b. Avoid performance testing – mile run, serial sprints, etc.
 - c. Build up intensity slow with training
 - d. Additional rest and recovery as needed between repetitions at practices, conditioning, and competitions
 - e. Avoid pushing all out for more than 2-3 minutes without rest and recovery

- f. Stay well hydrated – dehydration increases risk for exertional sickling episode
 - g. Stop activity if the athlete begins having signs and symptoms of exertional sickling
 - h. If they have asthma, work on controlling it with athlete.
 - i. Avoid working out and physical activity when an athlete with sickle cell trait is ill
4. If an exertional sickling episode occurs with an athlete, treatment includes:
- a. Monitoring vitals
 - b. Contact EMS (911) immediately and follow EAP
 - i. Inform them of exertional sickling event specifically
 - c. Administer High Flow Oxygen (if available)
 - d. Attach AED to athlete
 - e. Transport athlete to hospital
5. Health care professionals overseeing athlete with sickle cell trait should monitor for metabolic precautions.

Exertional Heat Illness

Heat illnesses commonly occur in all sport. They are typically associated with athletes exercising in the heat, however, may occur in “normal” environmental conditions. Prevention, recognition, and appropriate care of heat illnesses are important components of sports medicine. Effective protocols and management of heat illnesses could minimize the risk and improve the care of heat illnesses in athletes.

Types of heat illnesses:

1. Exercise Associated Muscle Cramps
 - a. Sudden or progressive painful contractions of the muscles during or after physical activity
 - b. Signs and symptoms: stiffness, tremors, contractures of the muscle
 - c. Typically occur due to dehydration, electrolyte imbalances, altered neuromuscular control, and/or fatigue
 - d. Treatment: rehydration, stretching, ice massage
2. Heat Syncope, “fainting”
 - a. May occur due to extended exposure in the heat and dehydration
 - b. Treatment: Move to a cool area, rehydrate
3. Heat Exhaustion
 - a. Elevated core temperature
 - b. Signs and symptoms: extreme weakness, dehydration, coordination problems, syncope, profuse sweating, paleness, headache, muscle cramps, vomiting
 - c. Treatment: move to cool area, put athlete in a cold immersion tub, rehydrate, monitor vitals, ice towels or ice bags (if cold tub is unavailable)
4. Exertional Heat Stroke

a. MEDICAL EMERGENCY

- i. Most severe heat illness
- b. Elevated core body temperature 105 degrees Fahrenheit or above
 - i. The body has lost control of cooling its thermoregulatory system
- c. Due to excessive heat production and/or inhibited heat loss
- d. Athlete will have altered CNS function
- e. Treatment: COOL IMMEDIATELY and CALL EMS (911)
 - i. Cold immersion tub until shivering at least (Ice towels, ice bags, move to cool AC area if tub is not available) ii. Monitor vitals until EMS arrives

Recommendations on Heat Illness:

1. Athletic Trainers, First Responders, Coaches, Athletic Director, Assistant Athletic Directors, and Athletes should be educated on prevention, recognition (signs and symptoms), and treatment of heat illnesses
2. All teams/athletes should follow the recommendations for heat acclimatization – including hydration, equipment, practice intensity and time.

3. WBGT should be monitored daily and adjustments to practice should be made as directed by the Athletic Trainer when necessary
4. If an athlete is suspected to be suffering from a heat stroke, they should be placed in the cold immersion tub, EMS should be contacted, and personnel should follow the EAP
5. Athletes who suffer from a heat stroke, must be cleared by a physician to continue participating in sports
6. Athletes who typically have difficulty with heat acclimatization and/or have suffered from heat illness in the past should be more precautionous at the beginning of preseason

Anaphylaxis

Anaphylaxis is an acute allergic reaction to an antigen to which the body has become hypersensitive.

Recommendations

1. Documentation of known anaphylactic allergy to bee stings, foods, medications, etc should be on file with the athletic trainer
 - a. Describe symptoms that occur
 - b. What action to take if specific symptoms occur
2. Students with known anaphylactic allergy should have a rescue prescription medication (usually an EPI-PEN)
 - c. Readily available during games, practices, and conditioning
 - d. Athletic trainer should have an extra supply of the rescue medication prescribed individually for each athlete as back up a.c. Before each activity examine to be certain it is functional, and containing medication that is within expiration date

Nutrition

According to the NATA, dietary energy (energy that comes from food) not only supports athletic performance but also sustains life. Following an athlete's participation in exercise, whatever remaining fuel left in their body is used to support the body's metabolic processes. Thus, when an athlete's body is not adequately fueled, there is little energy left to support the body's critical functions following intense training, such as recovery and repair. When dealing with nutrition with athletes, there are additional components to consider such as:

1. Recognition, prevention, and management of disordered eating in athletes
2. Appropriate and safe weight loss in athletes
 - a. Preseason b. Particular sports, such as wrestling
3. Use of supplements

Recognition, prevention, and management of disordered eating in athletes:

1. Disordered eating may be characterized by several elements, including but not limited to: concerns about body weight and shape, poor nutrition and low caloric intake, binge eating, use of laxatives, diuretics, and diet pills unnecessarily, and extreme weight control measures
 - a. Athletes may also exercise excessively, fast, and/or vomit
 - b. Disordered eating may lead to adverse effects mentally and physically. In addition, may affect an athlete's ability to physical perform in their sport
2. If an athlete is suspected of disordered eating, the Athletic Trainer should be notified in addition to the parent/guardian.
 - a. Once the Athletic Trainer has been notified, the proper steps will be taken to ensure the athletes safety and health.
 - i. Development of a health care team for the athlete (including medical physician, nutritionist, professional with mental health, and athletic trainer)
3. Parents/guardians, coaches, and Athletic Directors should also be included with updates on how the athlete is progressing ii. Develop a management protocol
4. Health care personnel at BMHS (including the Athletic Trainer and First Responder), Coaches, Athletic Administrators, and Athletes should be educated on recognition (signs and symptoms), prevention, and management of disordered eating
5. Coaches should not discriminate athletes based on body weight and associate body weight with performance

Appropriate and safe weight loss in athletes:

1. Athletic Trainers, First Responders, Coaches, and Athletes should be educated on appropriate and safe

weight loss in athletes.

2. Body weight management should be based on dietary elements and physical activity.

3. Weight loss should occur gradually.

a. Athletes should not be losing more than 1-2 pounds per week.

b. Athletes should not lose more than 3% of body weight in one day (i.e., the athlete's body weight should be within 3% of their body weight from the day before)

i. Football and soccer athletes should weigh in and weigh out during preseason

4. Wrestling should follow the standards established by the NCHSAA on weight loss and appropriate weight class.

Mental Health

The number of athletes in society continues to grow, including in the high school level. Many student-athletes form identities based on being an athlete. Therefore, they may experience challenges with their identities when they are struggling with performance; experience a chronic, career-ending, or time-loss injury; have conflicts with coaches and teammates; or lose the love for their sports. In addition, these student-athletes undergo the "normal" daily challenges with school and home life. As a result, they may experience changes with their mental health.

Recommendations for Mental Health recognition and management:

1. Athletic Trainers, First Responders, Athletic Administrators, Coaches, and Athletes should be educated on mental health, the recognition of negative changes in mental health, causes of changes in mental health, and proper management of mental health with athletes

a. Recognize possible stressors and triggers for student-athletes

i. Physical (training, injuries, environmental conditions) ii. Mental (game strategy, understanding plays, time with family, meeting expectations of self, teammates, and coaches) iii. Academic (classes, grades, study time)

b. Changes in behaviors of the athletes: changes in eating and/or sleeping habits, unexplained weight loss/gain, drug/alcohol abuse, withdrawal from social contact, decreased interest in activities, loss in emotion/sudden changes in emotion, problems concentrating, negative self-talk, agitation/irritability, frequent complaints of fatigue or injuries

2. If an athlete is suspected of having a negative change in mental health, the parents/guardians and Athletic Trainer should be notified.

a. Once the Athletic Trainer has been notified, the proper steps will be taken to ensure the athlete's safety and health.

i. Development of a health care team for the athlete (including medical physician, nutritionist, professional with mental health, and athletic trainer)

3. Parents/guardians, coaches, and Athletic Directors should also be included with updates on how the athlete is progressing

4. School counselors and nurses would also be beneficial to be a part of the team

ii. Develop a management protocol

5. The pre-participation physical should address mental health and provide history of any mental health issues to be concerned about with the student-athlete

Resources

NCHSAA Health and Safety Guidelines (NCHSAA.com)

National Athletic Trainers' Association Position Statement: Management of Asthma in Athletes (NATA.org)

The Inter-Association Task Force for Preventing Sudden Death in Secondary School Athletics Programs: Best- Practices Recommendations (NATA.org)

National Athletic Trainers' Association Position Statement: Acute Management of the Cervical Spine– Injured Athlete (NATA.org)

National Athletic Trainers' Association Position Statement: Lightning Safety for Athletics and Recreation (NATA.org)

Preseason Heat-Acclimatization Guidelines for Secondary School Athletics (NATA.org)

National Athletic Trainers' Association Position Statement: Fluid Replacement for Athletes (NATA.org)

National Athletic Trainers' Association Position Statement: Skin Diseases (NATA.org)

CDC.org

Consensus Statement: Sickie Cell Trait and the Athlete (NATA.org)

NCAA Sports Science Institute – Sickie Cell Trait (ncaa.org)

National Athletic Trainers' Association Position Statement: Exertional Heat Illnesses (NATA.org)

National Athletic Trainers' Association Position Statement: Preventing, Detecting, and Managing Disordered Eating in Athletes (NATA.org)

National Athletic Trainers' Association Position Statement: Safe Weight Loss and Maintenance Practices in Sport and Exercise (NATA.org)

Interassociation Recommendations for Developing a Plan to Recognize and Refer Student-Athletes with Psychological Concerns at the Secondary School Level: A Consensus Statement (NATA.org)

Appendix 4

Safe locations at Bishop McGuinness High School are as follows:

1. Main gym 2. Locker rooms 3. Athletic building 4. Car 5. Bus

Sexual Abuse/Assault Signs, Symptoms, and the Duty to Report

INTRODUCTION

The National Athletic Trainers' Association (NATA) Code of Ethics consists of principles, which guide our members' conduct on issues such as equitable treatment, regulatory compliance, positive representation of the athletic training profession, ethical conduct including appropriate relationships, and patient safety and advocacy.¹ The athletic trainer's primary responsibility is to the patient.

If at any time an athletic trainer (AT) suspects that an inappropriate behavior such as sexual abuse is occurring to a patient, it is the duty of the AT to report the perceived actions to the proper authorities. Failure to report any suspicion of sexual abuse to the proper authorities generally will be a NATA Code of Ethics violation and may also constitute a violation of state and/or federal laws, both of which have serious implications on one's athletic training certification and regulatory status.

Like all health care professionals, ATs enter a social contract with the public to assure them that they will provide trustworthy patient-centered care. The AT upholds the social contract by adhering to the standards of professional practice, including the NATA Code of Ethics, and engaging in evidence-based practice and continuous education. As such, the highest priority is the patient and quality care, which includes the recognition of the signs and symptoms of sexual abuse and awareness of our legal obligations.

AWARENESS OF SEXUAL ABUSE OF CHILDREN AND YOUTHS

Federal and state laws on child maltreatment establish acts or behaviors that define child abuse. The Federal Child Abuse Prevention and Treatment Act (CAPTA) has defined sexual abuse as, "the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children."²

Sexual abuse of a child includes activities such as fondling a child's genitals, penetration, incest, rape, sodomy, indecent exposure, and exploitation through prostitution or the production of pornographic materials.² While this definition is reported in child sexual abuse, the parameters also may apply to any adult sexual assault victim. Included in this description would be any patients that athletic trainers provide care or another person with whom they interact. A key element of sexual abuse or assault is that it involves any sexual act performed by one person on another without consent, but also may result from the use of unwanted sexual touching by the threat of force, coercion, or the inability of the victim to give consent, such as a minor child or an adult incapable of granting consent.

Protecting Young Victims from Sexual Abuse and Safe Sport Authorization Act of 2017³ is a federal law that was passed in January of 2018 to protect young athletes from sexual abuse. This Act extends the duty to report suspected child abuse to certain adults who are authorized to interact with minor or amateur athletes at a facility under the jurisdiction of a national governing body. A national governing body is an amateur sports organization that is recognized by the International Olympic Committee. Furthermore, it states that an individual who is required to report, but fails to do so, is subject to criminal penalties. **Without question, the duty to report under this regulation extends to athletic trainers.**

MANDATORY REPORTING OF DOMESTIC VIOLENCE TO LAW ENFORCEMENT BY HEALTH CARE PROVIDERS REPORTING ABUSE OF ADULTS

Most U.S. states have enacted mandatory reporting laws, which require the reporting of specific injuries and wounds, and suspected abuse or domestic violence for individuals treated by a health care professional. This pertains to all individuals to whom health care professionals provide treatment or medical care, or those who come before the health care facility.⁴ Since state laws vary from state to state, the AT is strongly advised to check his or her state's mandatory reporting laws for specifics and clarification.

SIGNS AND SYMPTOMS OF SEXUAL ABUSE AND ASSAULT

The AT must be aware of his or her mandated duty to report sexual abuse, regardless of the patient's age. Therefore, an important first step in fulfilling a mandatory reporting obligation is ability to recognize associated signs and symptoms. These signs and symptoms can be: 1) witnessed in person, 2) having a patient or another person with whom you interact with reporting the signs and symptoms, or 3) clear statements that one has felt sexually abused by another person.

The first step in helping patients or others who have been sexually abused, be it minor children or adults, is learning to recognize the signs and symptoms of abuse. The list below, though not fully inclusive, provide examples of signs and symptoms of a victim who has experienced sexual abuse or assault. The important point is to be aware of any changes in behavior that may be suggestive of sexual abuse or assault.

Child or teenager:

- Has difficulty walking or sitting
- Suddenly refuses to change for gym or to participate in physical activities
- Experiences a sudden change in appetite
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
- Becomes pregnant or contracts a venereal disease, particularly if under age 14
- Reports sexual abuse by a parent or another adult caregiver
- Behaves secretive or isolated
- Exhibits trouble in school with grades or behavioral issues
- Talks of death or suicide
- Shows little attachment to parent, guardian, or other significant adult in their life
- Avoids being around or making eye contact with certain individuals

Adult:

- Post-Traumatic Stress Disorder (PTSD) symptoms such as loss of appetite, trouble sleeping, hypervigilance, easily agitated over minor issues
- Declining grades or withdrawal from school
- Substance or alcohol abuse
- Risk taking behavior
- Loss of interest in activities that they used to enjoy, including sports participation
- Self-harm such as cutting or burning oneself
- Talk of death or suicide ideation

DUTY TO REPORT AND AVENUES FOR REPORTING OF SEXUAL ABUSE OR ASSAULT

The next step is to act on the knowledge or suspicion of sexual abuse or assault. Mandatory reporting of child sexual abuse is a legal and ethical responsibility of all athletic trainers.^{5, 1}

All states, the District of Columbia, American Samoa, the Northern Marianas, Guam, Puerto Rico and the U.S. Virgin Islands have statutes that identify persons who are required to report any suspected child maltreatment to an appropriate agency, such as child protective services or law enforcement, or toll-free reporting hotline.⁶ A good resource on mandatory reporting of child sexual abuse is Child Welfare Information Gateway, Mandatory Reporters of Child Abuse and Neglect.⁶ In this report, mandated reporters per state and American territories are defined. Clearly, athletic trainers fit into the health care provider categories listed in the report.

If an adult patient or an adult with whom the AT comes in contact is known to be, or suspected to be, a victim of sexual abuse or assault, the AT should report this to the proper authorities per state and federal law such as law enforcement or a toll-free hotline.

A mandatory report must be made when an AT suspects, or has reason to believe, that a child or adult has been sexually abused. The AT must immediately notify the Department of Children's Services or a law enforcement agency of the suspected abuse. What is NOT required in these laws is for the reporting chain to go through the ATs supervisor or administration. The place of employment, per employment guidelines, can also be notified, but there is no legal mandate to report to the employer. Notification to the proper legal authorities must come first if an employment guideline mandate reporting any sexual abuse to employment administration.

If an athletic trainer is the one suspected of committing sexual abuse or assault, in addition to reporting to the authorities identified previously, the individual also has a duty to report to the NATA and Board of Certification.

Summary

The ATs primary responsibility is to the patient, and this responsibility goes beyond providing quality health care; patient safety and advocacy are paramount. The athletic trainer must remain vigilant in recognizing and reporting possible sexual abuse or assault. It is important to remember that duty to report is based on the suspicion of abuse; evidence is not required. We recommend that ATs take a proactive approach in working with employers and school systems in establishing a protocol for employees to report suspected or known sexual abuse or assault of their patient, child or adult affiliated with the organization.