Bishop McGuinness High School

Emergency Action Policies Handbook

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

Last Revised September 2017

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Bishop McGuinness High School Emergency Action Plan

EMERGENCY CONTACT NUMBERS

Head Athletic Trainer (Brittany Price) (336) 564-1257
Athletic Director (Jeff Stoller (336) 707-3252)
Assistant Athletic Director (Drew Hackett (609) 273-0677)

HEALTH CARE TEAM

Brittany Price, Head Athletic Trainer
Dwight Jacobs, First Responder
Dr. Chris Brumfield, Orthopedic Physician
Dr. Chris Mills, Primary Care Physician

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Introduction

Emergency situations may arise at anytime during athletic events. Expedient action must be taken in order to provide the best possible care to the 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 anytime 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 the area of 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 situation 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 situation 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 a number of 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, mangers, and coaches are good choices for this role. The third role, EMS activation, may be necessary in situations where emergency transportation is not already resent 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

- Making the Call
  - 911 (if available)
  - Telephone number for local police, fire department, and ambulance service
- Providing Information
  - Name and telephone number of caller, address of the emergency
  - Number of athletes
  - Condition of athletes

- First aid treatment initiated by the athletic trainer/first responder
- Specific directions a needed to locate the emergency scene (“come to south entrance of coliseum”)
- 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 particular 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 situation arise.

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. In the event that an ambulance is on site, there should be a designated location with rapid access to the site and a cleared route for entering/exiting the venue. 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 situation, the athlete should be transported by ambulance, where the necessary staff and equipment is available to deliver appropriate care. Emergency care providers should refrain from transporting unstable athletes in inappropriate vehicles. Care must be taken to ensure that the activity areas are supervised should the emergency care provider leave the site in transporting the athlete

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 before hand what administrator, teacher, or other personnel will be responsible for keeping the general 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 situation 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
• Lindsay Snyder, Athletic Trainer
• Coach Spencer Pasciolla, First Responder
• Jeff Stoller, Athletic Director
• Drew Hackett, Asst. Athletic Director, Head Football Coach
• Principal Tracy Shaw
• 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.


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North Carolina Hwy 66 S
Bishop McGuinness
Catholic High School
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Cafeteria (Wrestling and Cheerleading)

Emergency Personnel
• Team physicians (when applicable), Athletic Trainers, first responders, coaches, administrators.

Emergency Communication
• Lindsay Snyder, Athletic Trainer
• Coach Spencer Pasciolla, First Responder
• Jeff Stoller, Athletic Director
• Drew Hackett, Asst. Athletic Director, Head Football Coach
• Principal Tracy Shaw
• Phone line to the main office 336.564.1010

Emergency Equipment
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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.


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

Emergency Personnel
• Team physicians (when applicable), Athletic Trainers, first responders, coaches, administrators.

Emergency Communication
• Lindsay Snyder, Athletic Trainer
• Coach Spencer Pasciolla, First Responder
• Jeff Stoller, Athletic Director
• Drew Hackett, Asst. Athletic Director, Head Football Coach
• Principal Tracy Shaw
• 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.
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b. Emergency Phone Numbers: (Dial 9 for outside line if using school phone)
• EMS, Fire, Police: 911
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• 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.


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Gymnasium

Emergency Personnel
• Team physicians (when applicable), Athletic Trainers, first responders, coaches, administrators.

Emergency Communication
• Lindsay Snyder, Athletic Trainer
• Coach Spencer Pasciolla, First Responder
• Jeff Stoller, Athletic Director
• Drew Hackett, Asst. Athletic Director, Head Football Coach
• Principal Tracy Shaw
• 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.


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Softball field

Emergency Personnel
• Team physicians (when applicable), Athletic Trainers, first responders, coaches, administrators.

Emergency Communication
• Lindsay Snyder, Athletic Trainer
• Coach Spencer Pasciolla, First Responder
• Jeff Stoller, Athletic Director
• Drew Hackett, Asst. Athletic Director, Head Football Coach
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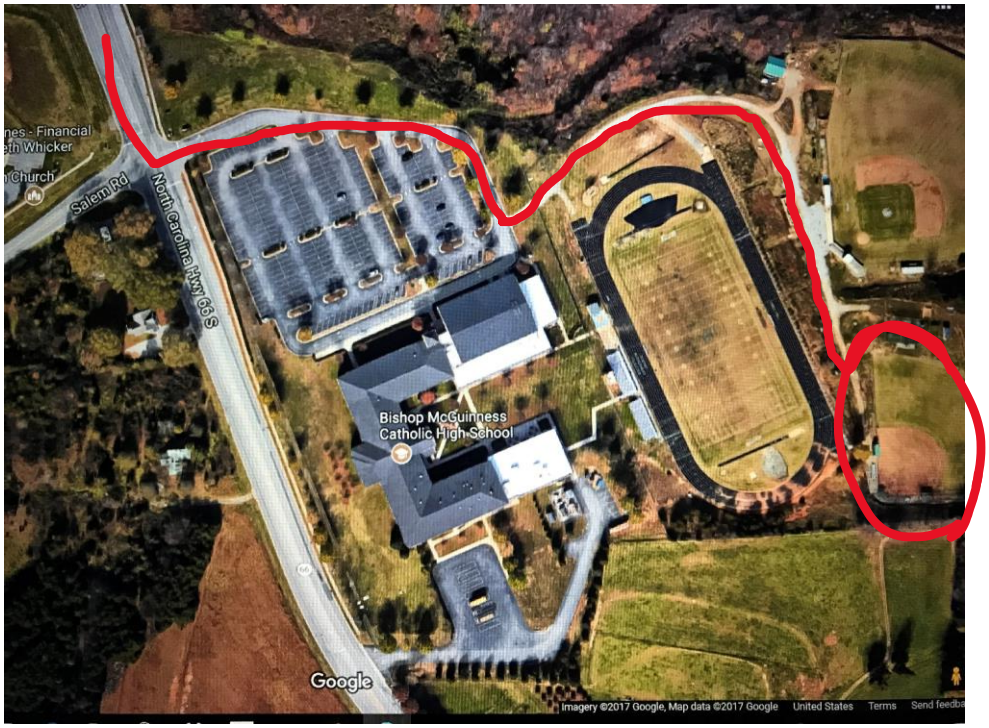
• Caller's Name?
• What happened?
• How many people are injured?
• Condition of injured person(s)?
• Help being provided
**Notify parents as soon as possible (Consent papers, have parent contact numbers).

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.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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.

- The vast majority of 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 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)
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
    - Heat Stroke is a MEDICAL EMERGENCY. Contact EMS (911) if you suspect an athlete is experiencing a heat stroke
    - 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!
    - Remove excessive clothing and equipment
    - 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.
    - Monitor vital signs
    - 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 Lightening 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 lightening safety, including the implementation of a lightening-safety policy that identifies safe locations for shelter from lightening 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 personal should monitor vital signs and if deemed necessary perform CPR until EMS arrives.

Safe locations during lighting 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 anytime 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 heck-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
        i. 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.
1. 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 (eg, pollen, dust mites, animal dander), pollutants (eg, carbon dioxide, smoke, ozone), respiratory infections, aspirin, nonsteroidal anti-inflammatory drugs (NSAIDs), inhaled irritants (eg, cigarette smoke, household cleaning fumes, chlorine in a swimming pool), particulate exposure (eg, 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 conditional 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
        a. Athletes with exercise-induced asthma (EIA) may benefit from use of short and long-acting b2-agonists.
        b. When used to prevent EIA, a short-acting b2-agonist, such as albuterol, should be inhaled 10 to 15 minutes prior to exercise.
        c. The excessive need for short-acting b2-agonists therapy during practice or an athletic event should cause concern. A physician should evaluate the athlete before returning to participation.
    b) All athletes with asthma should have their rescue inhaler readily available to them at practices, conditioning sessions, and games.
        a. Athletes should be educated on when they should use their inhaler and how to properly use it.
    c) If available, Athletic Trainers should have an extra rescue inhaler available for emergency situations.
    d) 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.
    e) Athletes should have regular check-ups to manage changes in asthma.
    f) 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.
        a. Gloves will 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 toe nail, 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 disposable of items soiled by bodily fluids and blood.
    b) Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood of bodily fluids. Hands should be washed immediately after gloves are removed.

        a. 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
    c) Surfaces contaminated with blood should be cleaned with any OSHA approved disinfectant solution.
        a. 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 table top surfaces daily.
    d) 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.
        a. 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 athlete's 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
        a. 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 differential 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
        a. Avoid performance testing – mile run, serial sprints, etc.
    b) Build up intensity slow with training
    c) Additional rest and recovery as needed between repetitions at practices, conditioning, and competitions
        a. Avoid pushing all out for more than 2-3 minutes without rest and recovery

d) Stay well hydrated – dehydration increases risk for exertional sickling episode
e) Stop activity if the athlete begins having signs and symptoms of exertional sickling
f) If they have asthma, work on controlling it with athlete.
g) 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
      a. 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 shriving at least
         1. Ice towels, ice bags, move to cool AC area if tub is not available
      ii. Monitor vitals until EMS arrives

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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 precautious at the beginning of preseason

~~d.~~

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)
   a. Readily available during games, practices, and conditioning
   b. 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:

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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 athletes 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)
            1. Parents/guardians, coaches, and Athletic Directors should also be included with updates on how the athlete is progressing
        ii. Develop a management protocol
3. 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
4. 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)

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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 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)
            1. Parents/guardians, coaches, and Athletic Directors should also be included with updates on how the athlete is progressing
            2. School counselors and nurses would also be beneficial to be a part of the team
        ii. Develop a management protocol
3. The pre-participation physical should address mental health and provide history of any mental health issues to be concerned about with the student-athlete

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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: Sickle Cell Trait and the Athlete (NATA.org)

NCAA Sports Science Institute – Sickle 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)

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