
# STANDARD OPERATING PROCEDURES & EMERGENCY ACTION PLAN

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BENJAMIN FRANKLIN HIGH SCHOOL

Amber R. Herr, AT, ATC

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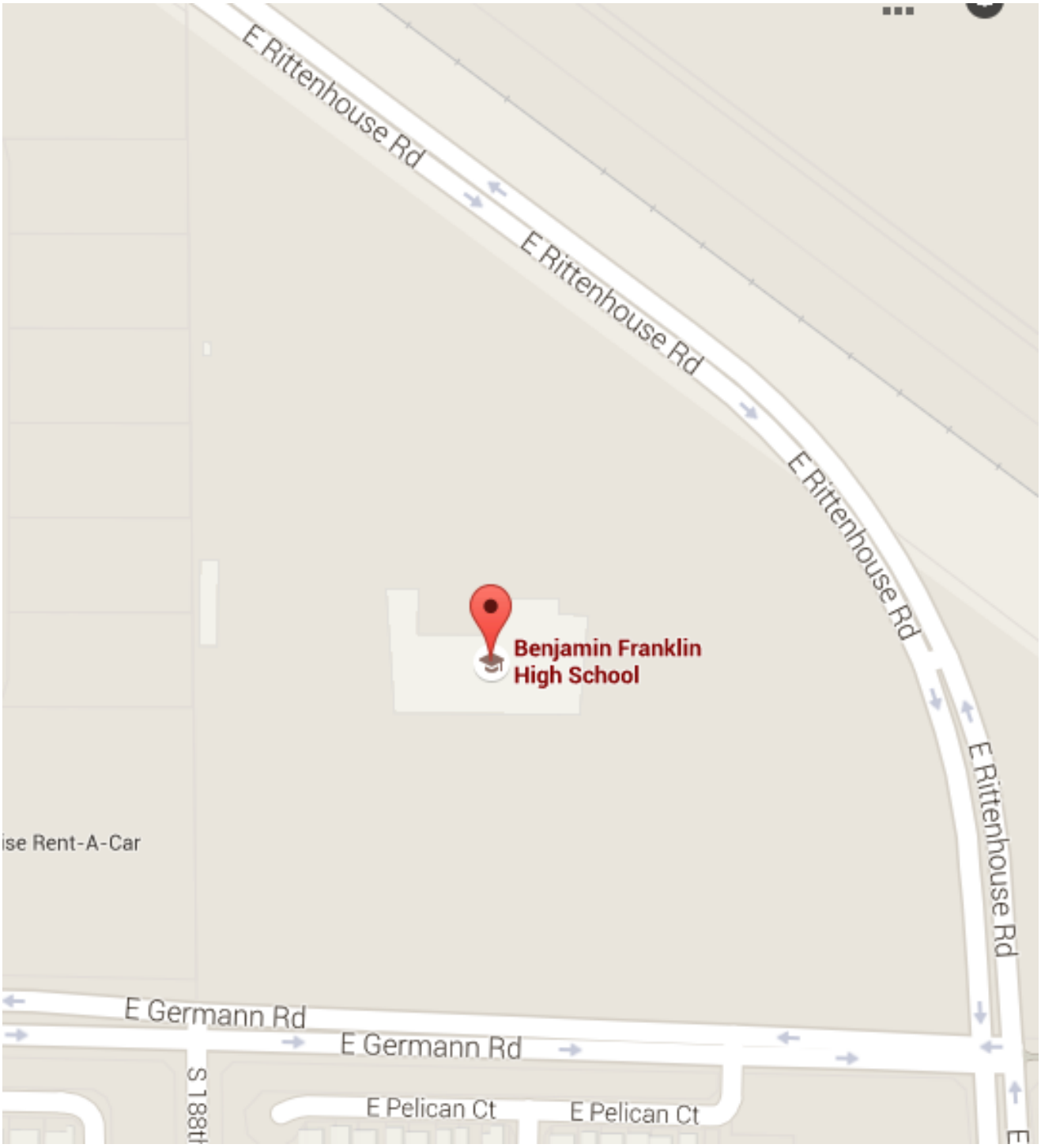
# Venue Maps


E Rittenhouse Rd
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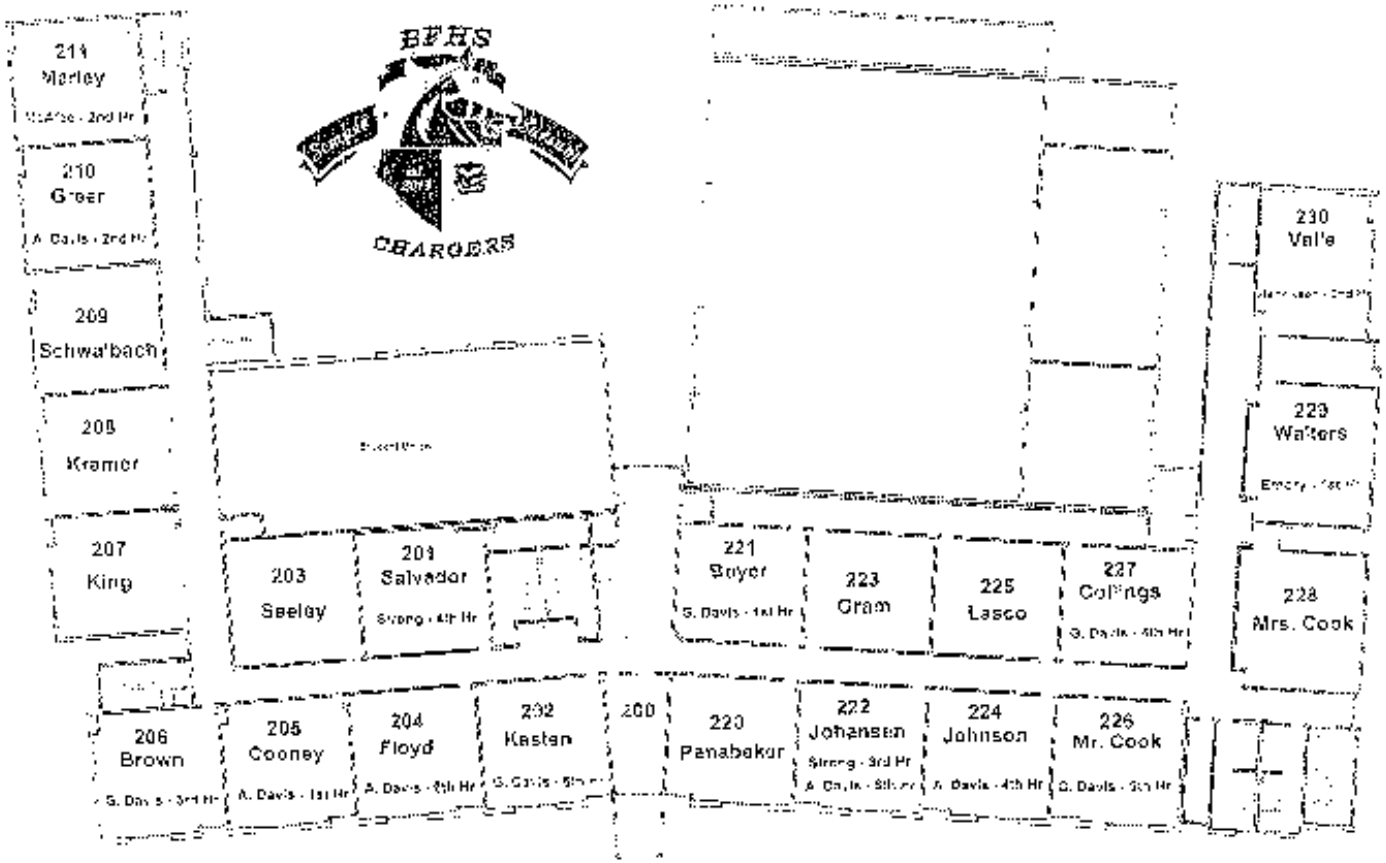
E Rittenhouse Rd
Benjamin Franklin
High School
ise Rent-A-Car
E Germann Rd
E Germann Rd
S 188th
E Pelican Ct
E Pelican Ct


E German Rd

# Venue Diagrams

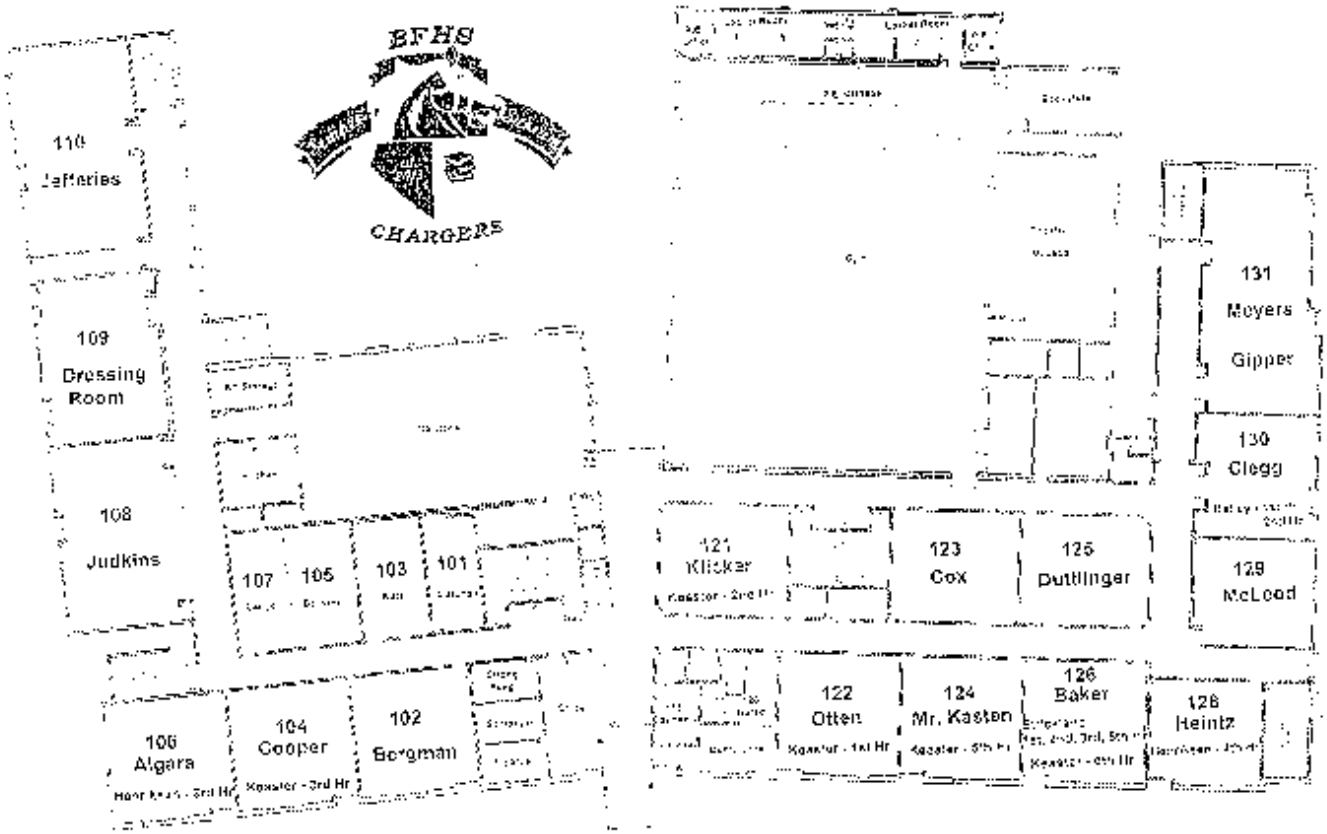
# Benjamin Franklin High School

Second Floor



# Benjamin Franklin High School

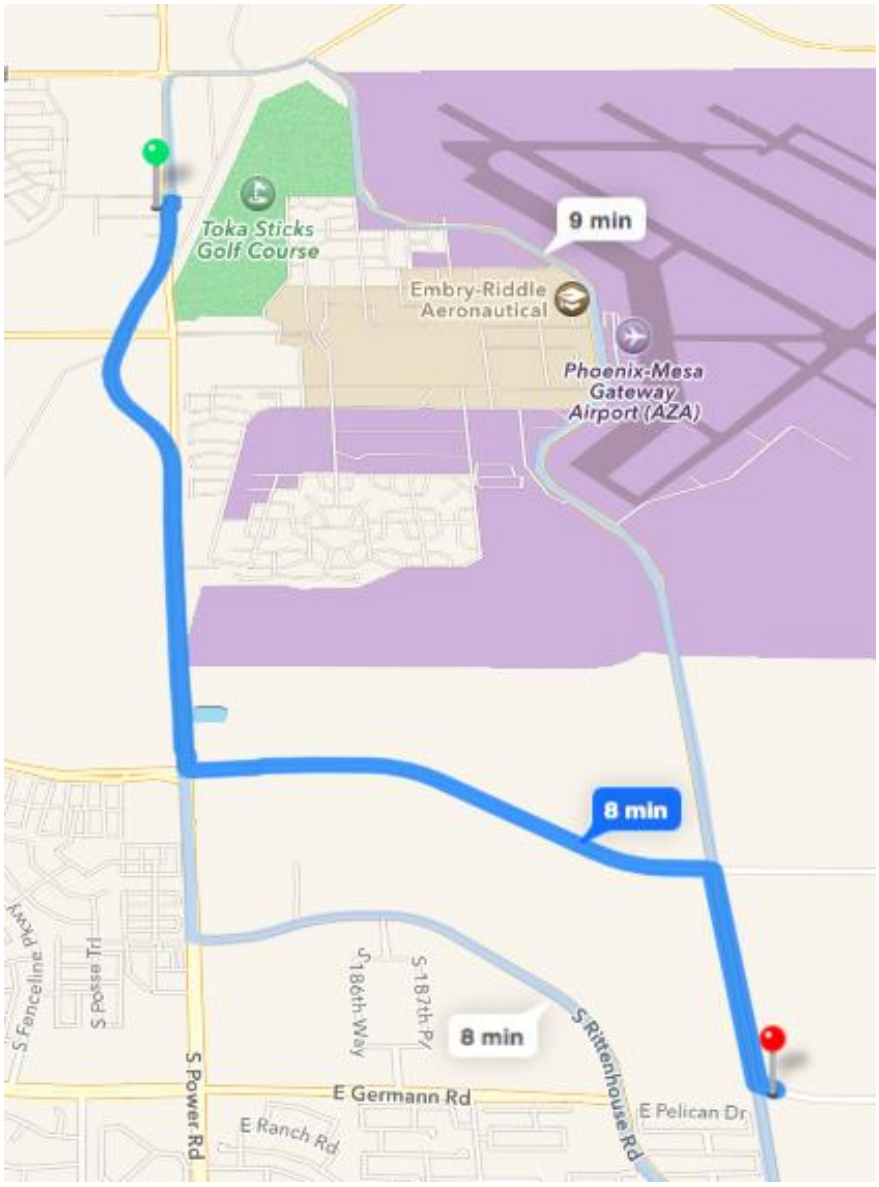
First Floor




CHARGERS
CHARGERS

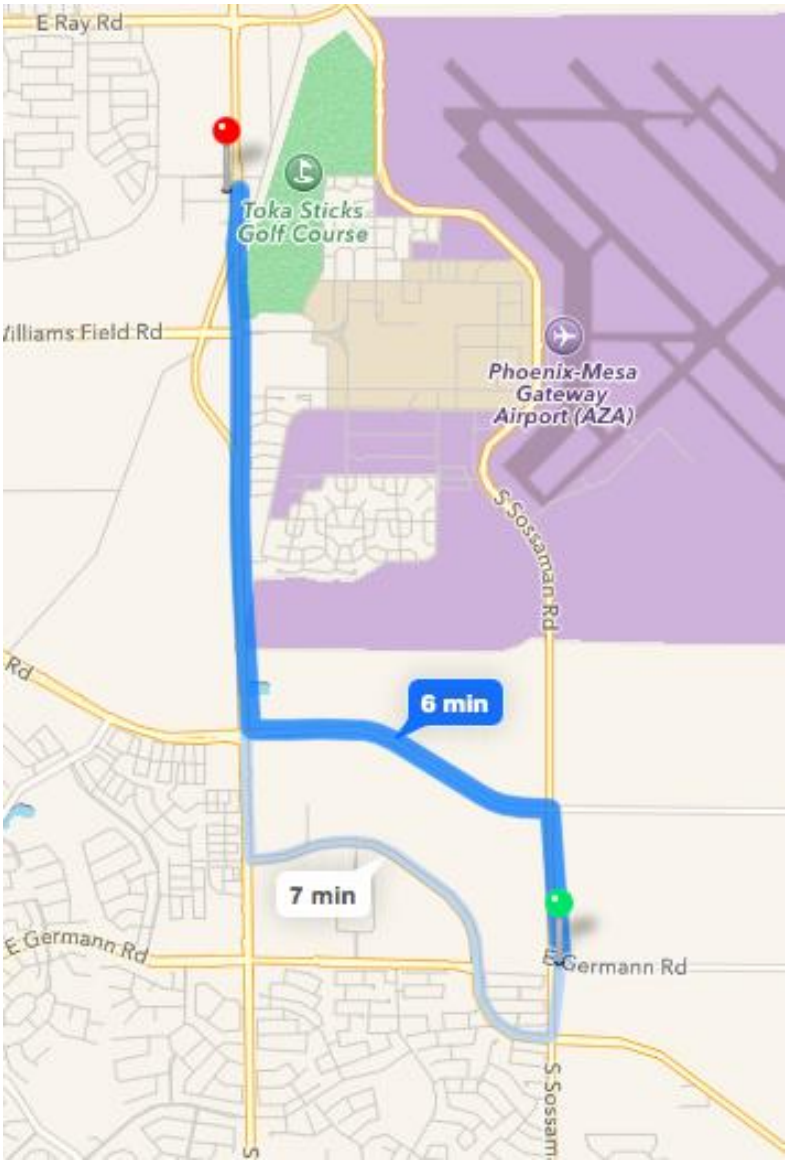
# Venue Written Directions

## From Gilbert Hospital to Benjamin Franklin High School




1. Start at Gilbert Hospital – 5656 S. Power Road, Gilbert, AZ 85295-8487, United States
2. In 285 feet, make a u-turn at E Galveston St
3. In 1.8 miles, turn left onto E Pecos Rd
4. In 1 mile, Turn right onto S Sossaman Rd
5. In 0.5 miles, Turn left onto E Germann Rd
6. In 148 feet, the destination is on your right
7. Arrive at Benjamin Franklin High School, 18864 E Germann Rd, Queen Creek, AZ 85142

## From Benjamin Franklin High School to Gilbert Hospital




1. Start at Benjamin Franklin High School, 18864 E Germann Rd, Queen Creek, AZ 85142
2. In 148 feet, at the end of the road, turn right onto S Sossaman Rd
3. In 0.5 miles, turn left onto E Pecos Rd
4. In 1 mile, turn right onto S Power Rd
5. In 1.7 miles, the destination is on your left
6. Arrive at Gilbert Hospital, 5656 S Power Rd, Gilbert, AZ 85295-8487, United States

# Phone Locations/ Emergency Contact Information

## Emergency Contact Information

**Phone Locations:**

- Main Office in High School
- All Classrooms in High School
- Coach's Offices
- One Student will be responsible for dialing 911 OR one of the other mentioned numbers in case of an emergency

**Emergency Phone Numbers:**

- Amber Herr, AT, ATC: (724) 674-4886
- Jeremy Strong: (402) 469- 5440
- Dr. Lafe Harris,DO: (480)204-0550

- Gilbert EMS: 911 5656 S. Power Rd, Gilbert, AZ 85295

- Gilbert Hospital: (480) 984- 2000

- Queen Creek Fire Department Station #412: 911

- American Association of Poison Control Centers: 1(800) 222-1222

**When Calling Have the Following Information:**

**Head coach will be responsible for calling 911 in case of emergency**

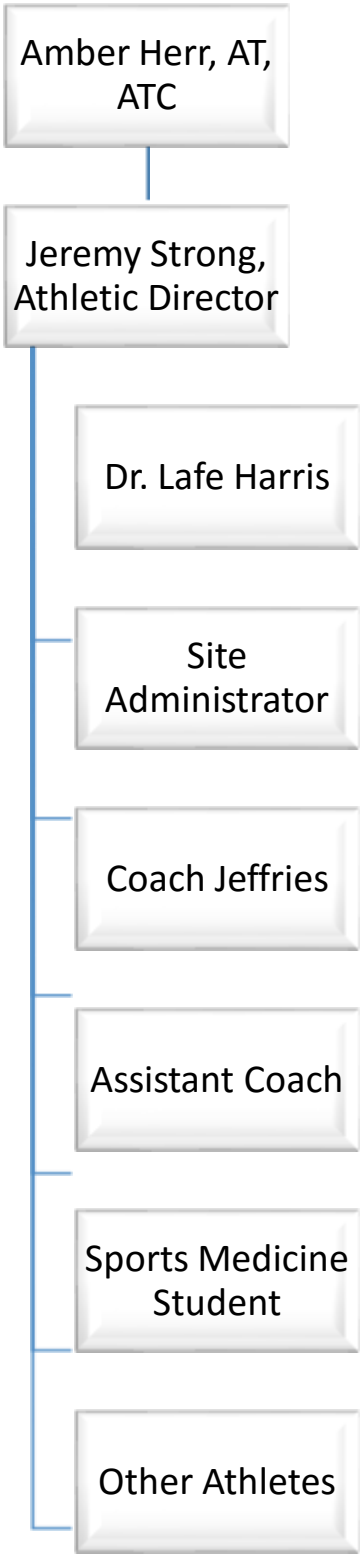
- Your name
- Your location: Benjamin Franklin High School, 18864 E Germann Rd, Queen Creek, AZ 85142
- Phone number you are calling from OR that you can be reached at
- Number of patients involved
- Name and age of patient(s)
- Nature of incident

**In case of Emergency:**

- Begin CPR, rescue breathing or intervention for choking as indicated
- CPR mask is located in the athletic training kit
- AEDs are located in the weight room and in the gymnasium (both in the high school)
  - Jeremy Strong will be responsible for obtaining the AED in case of emergency
- CPR:
  - Child and adult- 30 compressions, 2 breaths
- Rescue breathing:
  - Child- 1 breath every 3 seconds
  - Adult: 1 breath every 5 seconds

- Perform Heimlich maneuver for conscious choking patients
- Perform abdominal thrusts for unconscious adult choking patients
- Perform chest compressions for unconscious child choking patients

# Communication Tree


Amber Herr, AT, ATC
Jeremy Strong, Athletic Director
Dr. Lafe Harris
Site Administrator
Coach Jeffries
Assistant Coach
Sports Medicine Student
Other Athletes

# Emergency Equipment

# Emergency Equipment

**Automated External Defibrillator(s) (AED)**

- **Locations:**
  - Weight room
  - Outside nurse's office
  - OR with Athletic Trainer if during game (weight room AED is taken to field during games)

**CPR Mask:**

- With Athletic Trainer

**Crutches:**

- In weight room

# Equipment Removal

## Equipment Removal

In case of a medical emergency, specifically a c-spine injury, where equipment needs removed, both the helmet and shoulder pads will be removed. Only trained individuals will assist in removing equipment and properly transporting the injured athlete.

NATIONAL ATHLETIC TRAINERS' ASSOCIATION
HEALTH CARE FOR LIFE & SPORT

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# NATA Releases Executive Summary of Appropriate Care of the Spine Injured Athlete Inter-Association Consensus Statement

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Publications
- NATA News
- NATA Now Blog
- Journal of Athletic Training
- AT Education Journal
- Books
- Range of Motion

Do Business with NATA

Wednesday, June 24, 2015

**UPDATE (As of 8/5/15):** *NATA has received input from our membership and other organizations regarding the recent release of the Executive Summary from the Task Force on the Appropriate Prehospital Management of the Spine-Injured Athlete. The Task Force believes that the positions taken foster a "best practices" approach for our patients now and in the future. While we support the many locations that have already begun training initiatives for equipment removal, the Task Force does appreciate that the implementation of the positions nationally will take time and dedication. We believe that the input merits altering the wording to allow for greater flexibility.*

*To that end, the Task Force core writing group has proposed revising Recommendation #4 from reading "....equipment should be removed prior to transport" to "when appropriate, protective equipment may be removed prior to transport." The Task Force recognizes the variations in state emergency medical system protocols nationally, the availability of qualified EMS systems and hospital emergency departments locally, the differences in personnel and resources at various venues and levels of competition, and the uniqueness inherent in each situation and with each patient. These, along with medical-legal liability issues, lead us to conclude that it is prudent to state that health care providers make the decision regarding equipment removal on site based on the individual circumstances of the case.*

*Once the "Appropriate Prehospital Management of the Spine-Injured Athlete" statement is completed, reviewed, and approved by the professional organizations represented at the task force meeting, educational materials will be developed by NATA and other groups to assist those health care providers whose education and professional training may not include various components of the recommendations outlined in the consensus statement.*

*A list of frequently asked questions is currently in development. You may contact Katie Scott, MS, ATC, LAT, with any additional questions.*

# In case of Athletic Trainer's Absence

**If no Athletic Trainer Present**

In the event that an athletic trainer is not available, Jeremy Strong becomes the person in charge of medical scenarios. In any emergency situation, 911 should be called immediately. The athletic trainer should be informed of any situation that has occurred in his or her absence.

# General Policies

The following depicts general policies and procedures that should be followed:

- Coaches may communicate with the athletic trainer either via text message, phone call or email, with email being the preferred method of communication.
- Coaches/staff are responsible for reading through the EAP/ SOP and acknowledging that they have done so in a timely manner after it has been distributed.
- Coaches/staff are responsible for responding to athletic trainer's emails/ calls/ text messages within a timely manner
- Coaches/staff are responsible for complying with the EAP/SOP and any policies that are set in place throughout the year in addition to the EAP/ SOP
- Coaches/ staff will notify the athletic trainer of any changes or cancellations in events, practices, games, or location at least 24-hours in advance of the scheduled aforementioned event

# Return to Play Policy

**Return to Play Policy:**

Once an athlete has been referred to a team physician, he or she must be cleared by the medical team. This team includes the team physician(s), athletic director, and athletic trainer. The medical team must be in agreeance that the athlete is cleared to return to play prior to the decision being made. An athlete is not permitted to return to play without clearance from all personnel included above. Athletes are not permitted to obtain clearance from other physicians without the consent of the medical team listed above. For concussions, athletes are required by law to see a neurologist, sports medicine physician or athletic trainer for the proper and legal clearances. For musculoskeletal injuries, athletes must see an orthopedic physician, sports med physician or athletic trainer for the proper clearance. For general illnesses, athletes are permitted to see their primary care physician (PCP). All final return to play decisions are made by Amber under the direction of Dr. Harris. They have the right to accept or refuse any "clearances" provided by other physicians. All decisions are made in the best interest of the health of the athletes. Please see the concussion section for specific return to play policies on concussions.

# Lightning Policy

## Lightning Policy:

According to the National Athletic Trainers' Association, "lightning is the most dangerous and frequently encountered thunderstorm hazard that people experience every year." The following pages highlight recommendations, general weather considerations, safe locations, unsafe locations, and safety considerations. The plan also depicts the 4 specific criteria to follow when lightning does occur. Please see the image on the following page for the flash-to-bang theory. Once lightning has been detected, play must be postponed for at least 30 minutes after the last flash of lightning. Each time lightning flashes, the 30 minutes' restarts.

- Board Meetings
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- About EMSA
- EMSAcare Member Center
- Safety Resource Center
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## Lightning Safety Tips

Lightning is an extremely powerful and dangerous part of summer's weather. Generally speaking, if you can see lightning or hear thunder, you need to take precautions to avoid being hit by lightening.

Don't take chances. The electrical charge and intense heat of lightning can electrocute on contact.

There is an accepted method for estimating the distance of an approaching thunderstorm. The "Flash-To-Bang" theory measures the time from when you see lightning to the time you hear the associated thunder. A measure of 5 seconds from Flash-To-Bang means lightning is one mile away. Ten seconds equals 2 miles; 15 seconds equals 3 miles, etc. When the Flash-to-Bang count is 30 seconds, it's time to seek safe shelter. However, you should be aware of its pitfall. It is sometimes hard to associate the proper clap of thunder to the corresponding flash.

Seek shelter inside an enclosed building or metal vehicle such as a car, van, or truck, with windows completely shut. **Place your hands in your lap, and do not touch any metal on the vehicle**. This includes window and door handles, radios, gearshifts, steering wheels, and any inside-to-outside metal objects. Never run under an isolated tree. Lightning strikes split trees and spread across the ground. Pools of water and even appliances can become electrically charged.

If you are caught on a golf course in a thunderstorm, remove metal-spiked shoes, put down golf clubs and avoid electric carts. If possible, seek shelter in an enclosed building. Stay away from metal fences, pipes, and rails. Avoid open water, wet sand, tractors, metal equipment, and golf carts.

If you cannot reach safe shelter, crouch down, put feet together, hands over your ears. Don't huddle with others; keep about 15 feet between you and another person.

If you are at a ball field when a thunderstorm approaches, at the first signs of lightning or thunder, leave the field, go to your vehicle and roll the windows up; then put your hands in your lap and avoid touching any metal parts.

- Avoid rain and sun shelters and dugout areas.
- Do not seek shelter under a tree – they attract lightning.
- Avoid metal fences, gates and tall light or power poles.

If you are swimming in a pond or stream, designate one person to keep an eye on the weather. Keep a weather radio tuned to get local advance weather information. Plan where you will seek shelter if a storm comes up.

Remember that swimming pools are connected to a much larger surface area than the pool. Underground water pipes, gas lines, electric and telephone wires form a metallic network extending far beyond the pool itself. At the first clap of thunder, evacuate the pool. Do not stand around the pool on wet surfaces, but go inside where it is dry and safe. Stand away from windows and doors. Do not resume pool activities until 30 minutes after the last thunder is heard.

Lightning strikes the highest object on a body of water. On a lake, that highest object is a boat. Every boat has the potential to attract a lighting strike. Small fishing or sailboats constructed of aluminum or fiberglass are particularly vulnerable to lighting strikes. Even a graphic fishing rod is an excellent electrical conductor.

Always get a weather report from the National Weather Services prior to heading for the lake and carry a weather radio with you. Stay alert for dark, anvil-shaped clouds and distant lighting and thunder. Take no chances; head for shore at the first suspicion of an approaching storm.

Return to the Safety Resource Center

**Lightning and General Weather Awareness:**

- The weather will be monitored and reported by the athletic trainer on duty

**Safe Locations:**

- Inside the high school building
- Home
- Fully enclosed vehicles (i.e. cars, vans)
- School bus

**Unsafe Locations:**

- Picnic, park, sun, bus, rain nonmetal shelters
- Tents, dugouts, refreshment stands, press box, open garage
- Trees, poles, towers
- Swimming pools

**Lightning Criteria:**

| | |
|---|---|
| 1. "heads up" | lightning within 15 miles |
| 2. "Begin safety procedures" | lightning within 10 miles |
| 3. "you are now in danger; safety procedures should be complete | Lightning within 6 miles |
| 4. "All clear" | Lightning has not been detected at 15 miles for 30 minutes |

# Concussion Policy

## Concussion Policy

All employees and athletes must be educated regarding concussions. All athletes must sign a form noting that they have read and understand concussions and agree to report them (included in consent to treat form). As defined by the National Athletic Trainers Association, a concussion is "a trauma- induced alteration in mental status that may or may not involve loss of consciousness." The SCAT3 (or updated version, when applicable), along with concussion screenings will be used to help determine if an athlete has a concussion prior to referral to the team physician. Athletes who have symptoms for 5 days or less will be treated by the athletic trainer, cleared by the athletic trainer, and follow the same return to play protocol. Athletes who have symptoms for more than 5 days, lose consciousness, have other concerns, or parents prefer physician referral, will be referred to Dr. Harris. The following pages depict the signs and symptoms, treatment, prevention and management of concussions. An athlete that has a suspected concussion must be pulled from play, evaluated, and referred if needed. Any athlete that is pulled from play, and there is not an appropriate health care provider (athletic trainer, neurologist, sports med physician) on site to evaluate the injury, may NOT return to play until evaluated. Any athlete that is diagnosed with a concussion and referred to Dr. Harris must be cleared by him before completing the return to play procedures. **Return to play procedures will be provided by the team physician and followed strictly.**

The return to play progression for concussed athletes is as followed:

Day 1: symptom free
Day 2: light aerobic activity
Day 3: moderate aerobic activity
Day 4: non-contact practice
Day 5: full-contact practice
Day 6: game-play

The above return to play progression must be completed with Amber, the athletic trainer, unless otherwise noted by either Amber or Dr. Harris. All final return to play decisions are made by Amber under the direction of Dr. Harris.

In the event an athlete requires academic accommodations for their concussion, they will follow the following protocol: 3 days' full rest, followed by individualized accommodation plan set forth by Amber or Dr. Harris.

**Signs and symptoms: (may include some, all, or none of the following)**

- Headache
- Temporary loss of consciousness
- Confusion
- Feeling in a fog
- Amnesia
- Dizziness
- Ringing in the ears
- Nausea
- Vomiting
- Slurred speech
- Delayed response to questions
- Appearing dazed
- Fatigue
- Concentration complaints
- Irritability
- Sensitivity to light
- Sensitivity to noise
- Sleep disturbances
- Depression
- Disorders of taste
- Disorders of smell

**Mechanisms:**

- Any impact to the head
- Whiplash motion

**Prevention:**

- All coaches, employees, parents, guardians and athletes should be educated regarding concussions
- Proper protective equipment (i.e. helmets) must be utilized
- Proper hitting in football

**Home Care:**

- Both the athlete and the athlete's parents/ guardians should receive an information packet and home care
- The athlete should be informed to avoid medications other than acetaminophen
- Athlete should not ingest alcohol, illicit drugs, or other substances that may alter mental status
- Athlete should be instructed to get plenty of rest. Athlete should not be woken up throughout the night unless directed by the physician
- The athlete should avoid any physical or mental activity that intensifies the symptoms

- School administrators, counselors and instructors should be notified of the injury with recommendation for accommodation while the athlete is recovering from the injury
- The athlete should be eating a well-balanced diet and drinking plenty of water to remain hydrated

# SCAT3

## Sport Concussion Assessment Tool – 3rd Edition

For use by medical professionals only

Name | Date/Time of Injury: Date of Assessment: | Examiner:

### What is the SCAT3?[1]

The SCAT3 is a standardized tool for evaluating injured athletes for concussion and can be used in athletes aged from 13 years and older. It supersedes the original SCAT and the SCAT2 published in 2005 and 2009, respectively[2]. For younger persons, ages 12 and under, please use the Child SCAT3. The SCAT3 is designed for use by medical professionals. If you are not qualified, please use the Sport Concussion Recognition Tool[1]. Preseason baseline testing with the SCAT3 can be helpful for interpreting post-injury test scores.

Specific instructions for use of the SCAT3 are provided on page 3. If you are not familiar with the SCAT3, please read through these instructions carefully. This tool may be freely copied in its current form for distribution to individuals, teams, groups and organizations. Any revision or any reproduction in a digital form requires approval by the Concussion in Sport Group.

**NOTE**: The diagnosis of a concussion is a clinical judgment, ideally made by a medical professional. The SCAT3 should not be used solely to make, or exclude, the diagnosis of concussion in the absence of clinical judgement. An athlete may have a concussion even if their SCAT3 is "normal".

### What is a concussion?

A concussion is a disturbance in brain function caused by a direct or indirect force to the head. It results in a variety of non-specific signs and/or symptoms (some examples listed below) and most often does not involve loss of consciousness. Concussion should be suspected in the presence of **any one or more** of the following:

- Symptoms (e.g., headache), or
- Physical signs (e.g., unsteadiness), or
- Impaired brain function (e.g. confusion) or
- Abnormal behaviour (e.g., change in personality).

## SIDELINE ASSESSMENT

### Indications for Emergency Management

**NOTE:** A hit to the head can sometimes be associated with a more serious brain injury. Any of the following warrants consideration of activating emergency procedures and urgent transportation to the nearest hospital:

- Glasgow Coma score less than 15
- Deteriorating mental status
- Potential spinal injury
- Progressive, worsening symptoms or new neurologic signs

### Potential signs of concussion?

If any of the following signs are observed after a direct or indirect blow to the head, the athlete should stop participation, be evaluated by a medical professional and **should not be permitted to return to sport the same day** if a concussion is suspected.

| | | |
|---|---|---|
| Any loss of consciousness? | Y | N |
| "If so, how long?" | | |
| Balance or motor incoordination (stumbles, slow/laboured movements, etc.)? | Y | N |
| Disorientation or confusion (inability to respond appropriately to questions)? | Y | N |
| Loss of memory: | Y | N |
| "If so, how long?" | | |
| "Before or after the injury?" | | |
| Blank or vacant look: | Y | N |
| Visible facial injury in combination with any of the above: | Y | N |

### 1 Glasgow coma scale (GCS)

| | |
|---|---|
| **Best eye response (E)** | |
| No eye opening | 1 |
| Eye opening in response to pain | 2 |
| Eye opening to speech | 3 |
| Eyes opening spontaneously | 4 |
| **Best verbal response (V)** | |
| No verbal response | 1 |
| Incomprehensible sounds | 2 |
| Inappropriate words | 3 |
| Confused | 4 |
| Oriented | 5 |
| **Best motor response (M)** | |
| No motor response | 1 |
| Extension to pain | 2 |
| Abnormal flexion to pain | 3 |
| Flexion/Withdrawal to pain | 4 |
| Localizes to pain | 5 |
| Obeys commands | 6 |
| **Glasgow Coma score (E + V + M)** | of 15 |

GCS should be recorded for all athletes in case of subsequent deterioration.

### 2 Maddocks Score[3]

*"I am going to ask you a few questions, please listen carefully and give your best effort."*

Modified Maddocks questions (1 point for each correct answer)

| | | |
|---|---|---|
| At what venue are we at today? | 0 | 1 |
| Which half is it now? | 0 | 1 |
| Who scored last in this match? | 0 | 1 |
| What team did you play last week/game? | 0 | 1 |
| Did your team win the last game? | 0 | 1 |
| **Maddocks score** | | of 5 |

Maddocks score is validated for sideline diagnosis of concussion only and is not used for serial testing.

**Notes:** Mechanism of Injury ("tell me what happened"?):

**Any athlete with a suspected concussion should be REMOVED FROM PLAY, medically assessed, monitored for deterioration (i.e., should not be left alone) and should not drive a motor vehicle until cleared to do so by a medical professional. No athlete diagnosed with concussion should be returned to sports participation on the day of Injury.**

## BACKGROUND

Name: _____ Date: _____

Examiner: _____

Sport/team/school: _____ Date/time of injury: _____

Age: _____ Gender: ☐ M ☐ F

Years of education completed: _____

Dominant hand: ☐ right ☐ left ☐ neither

How many concussions do you think you have had in the past? _____

When was the most recent concussion? _____

How long was your recovery from the most recent concussion? _____

Have you ever been hospitalized or had medical imaging done for a head injury? ☐ Y ☐ N

Have you ever been diagnosed with headaches or migraines? ☐ Y ☐ N

Do you have a learning disability, dyslexia, ADD/ADHD? ☐ Y ☐ N

Have you ever been diagnosed with depression, anxiety or other psychiatric disorder? ☐ Y ☐ N

Has anyone in your family ever been diagnosed with any of these problems? ☐ Y ☐ N

Are you on any medications? If yes, please list: ☐ Y ☐ N

_____

SCAT3 to be done in resting state. Best done 10 or more minutes post excercise.

## SYMPTOM EVALUATION

### 3 How do you feel?

*"You should score yourself on the following symptoms, based on how you feel now".*

| | none | mild | | moderate | | severe | |
|---|---|---|---|---|---|---|---|
| Headache | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| "Pressure in 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 |
| Sensitivity to light | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Sensitivity 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 remembering | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Fatigue or low energy | 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 | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| More emotional | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Irritability | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Sadness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Nervous or Anxious | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

**Total number of symptoms** (Maximum possible 22) _____

**Symptom severity score** (Maximum possible 132) _____

Do the symptoms get worse with physical activity? ☐ Y ☐ N

Do the symptoms get worse with mental activity? ☐ Y ☐ N

☐ self rated ☐ self rated and clinician monitored

☐ clinician interview ☐ self rated with parent input

**Overall rating:** If you know the athlete well prior to the injury, how different is the athlete acting compared to his/her usual self?

Please circle one response:

| no different | very different | unsure | N/A |
|---|---|---|---|

**Scoring on the SCAT3 should not be used as a stand-alone method to diagnose concussion, measure recovery or make decisions about an athlete's readiness to return to competition after concussion. Since signs and symptoms may evolve over time, it is important to consider repeat evaluation in the acute assessment of concussion.**

## COGNITIVE & PHYSICAL EVALUATION

### 4 Cognitive assessment

**Standardized Assessment of Concussion (SAC)**[4]

**Orientation** (1 point for each correct answer)

| | | |
|---|---|---|
| What month is it? | 0 | 1 |
| What is the date today? | 0 | 1 |
| What is the day of the week? | 0 | 1 |
| What year is it? | 0 | 1 |
| What time is it right now? (within 1 hour) | 0 | 1 |
| **Orientation score** | | of 5 |

**Immediate memory**

| List | Trial 1 | | Trial 2 | | Trial 3 | | Alternative word list | | |
|---|---|---|---|---|---|---|---|---|---|
| elbow | 0 | 1 | 0 | 1 | 0 | 1 | candle | baby | finger |
| apple | 0 | 1 | 0 | 1 | 0 | 1 | paper | monkey | penny |
| carpet | 0 | 1 | 0 | 1 | 0 | 1 | sugar | perfume | blanket |
| saddle | 0 | 1 | 0 | 1 | 0 | 1 | sandwich | sunset | lemon |
| bubble | 0 | 1 | 0 | 1 | 0 | 1 | wagon | iron | insect |
| **Total** | | | | | | | | | |

**Immediate memory score total** of 15

**Concentration: Digits Backward**

| List | Trial 1 | | Alternative digit list | |
|---|---|---|---|---|
| 4-9-3 | 0 | 1 | 6-2-9 | 5-2-6 | 4-1-5 |
| 3-8-1-4 | 0 | 1 | 3-2-7-9 | 1-7-9-5 | 4-9-6-8 |
| 6-2-9-7-1 | 0 | 1 | 1-5-2-8-6 | 3-8-5-2-7 | 6-1-8-4-3 |
| 7-1-8-4-6-2 | 0 | 1 | 5-3-9-1-4-8 | 8-3-1-9-6-4 | 7-2-4-8-5-6 |
| **Total** of 4 | | | | | |

**Concentration: Month in Reverse Order** (1 pt. for entire sequence correct)

| | | |
|---|---|---|
| Dec-Nov-Oct-Sept-Aug-Jul-Jun-May-Apr-Mar-Feb-Jan | 0 | 1 |
| **Concentration score** | | of 5 |

### 5 Neck Examination:

Range of motion Tenderness Upper and lower limb sensation & strength

**Findings:** _____

### 6 Balance examination

Do one or both of the following tests.

Footwear (shoes, barefoot, braces, tape, etc.) _____

**Modified Balance Error Scoring System (BESS) testing**[5]

Which foot was tested (i.e. which is the **non-dominant** foot) ☐ Left ☐ Right

Testing surface (hard floor, field, etc.) _____

**Condition**

| | |
|---|---|
| Double leg stance: | Errors |
| Single leg stance (non-dominant foot): | Errors |
| Tandem stance (non-dominant foot at back): | Errors |

**And / Or**

**Tandem gait**[6,7]

Time (best of 4 trials): _____ seconds

### 7 Coordination examination

**Upper limb coordination**

Which arm was tested: ☐ Left ☐ Right

**Coordination score** of 1

### 8 SAC Delayed Recall[4]

**Delayed recall score** of 5

# INSTRUCTIONS

Words in *Italics* throughout the SCAT3 are the instructions given to the athlete by the tester.

## Symptom Scale

*"You should score yourself on the following symptoms, based on how you feel now".*

To be completed by the athlete. In situations where the symptom scale is being completed after exercise, it should still be done in a resting state, at least 10 minutes post exercise.
For total number of symptoms, maximum possible is 22.
For Symptom severity score, add all scores in table, maximum possible is 22 x 6 = 132.

## SAC[4]

### Immediate Memory

*"I am going to test your memory. I will read you a list of words and when I am done, repeat back as many words as you can remember, in any order."*

**Trials 2 & 3:**

*"I am going to repeat the same list again. Repeat back as many words as you can remember in any order, even if you said the word before."*

Complete all 3 trials regardless of score on trial 1 & 2. Read the words at a rate of one per second. **Score 1 pt. for each correct response.** Total score equals sum across all 3 trials. Do not inform the athlete that delayed recall will be tested.

### Concentration

**Digits backward**

*"I am going to read you a string of numbers and when I am done, you repeat them back to me backwards, in reverse order of how I read them to you. For example, if I say 7-1-9, you would say 9-1-7."*

If correct, go to next string length. If incorrect, read trial 2. **One point possible for each string length.** Stop after incorrect on both trials. The digits should be read at the rate of one per second.

**Months in reverse order**

*"Now tell me the months of the year in reverse order. Start with the last month and go backward. So you'll say December, November … Go ahead"*

**1 pt. for entire sequence correct**

### Delayed Recall

The delayed recall should be performed after completion of the Balance and Coordination Examination.

*"Do you remember that list of words I read a few times earlier? Tell me as many words from the list as you can remember in any order."*

**Score 1 pt. for each correct response**

## Balance Examination

**Modified Balance Error Scoring System (BESS) testing[5]**

This balance testing is based on a modified version of the Balance Error Scoring System (BESS)[5]. A stopwatch or watch with a second hand is required for this testing.

*"I am now going to test your balance. Please take your shoes off, roll up your pant legs above ankle (if applicable), and remove any ankle taping (if applicable). This test will consist of three twenty second tests with different stances."*

**(a) Double leg stance:**

*"The first stance is standing with your feet together with your hands on your hips and with your eyes closed. You should try to maintain stability in that position for 20 seconds. I will be counting the number of times you move out of this position. I will start timing when you are set and have closed your eyes."*

**(b) Single leg stance:**

*"If you were to kick a ball, which foot would you use? [This will be the dominant foot] Now stand on your non-dominant foot. The dominant leg should be held in approximately 30 degrees of hip flexion and 45 degrees of knee flexion. Again, you should try to maintain stability for 20 seconds with your hands on your hips and your eyes closed. I will be counting the number of times you move out of this position. If you stumble out of this position, open your eyes and return to the start position and continue balancing. I will start timing when you are set and have closed your eyes."*

**(c) Tandem stance:**

*"Now stand heel-to-toe with your non-dominant foot in back. Your weight should be evenly distributed across both feet. Again, you should try to maintain stability for 20 seconds with your hands on your hips and your eyes closed. I will be counting the number of times you move out of this position. If you stumble out of this position, open your eyes and return to the start position and continue balancing. I will start timing when you are set and have closed your eyes."*

**Balance testing – types of errors**

1. Hands lifted off iliac crest
2. Opening eyes
3. Step, stumble, or fall
4. Moving hip into > 30 degrees abduction
5. Lifting forefoot or heel
6. Remaining out of test position > 5 sec

Each of the 20-second trials is scored by counting the errors, or deviations from the proper stance, accumulated by the athlete. The examiner will begin counting errors only after the individual has assumed the proper start position. **The modified BESS is calculated by adding one error point for each error during the three 20-second tests. The maximum total number of errors for any single condition is 10.** If a athlete commits multiple errors simultaneously, only one error is recorded but the athlete should quickly return to the testing position, and counting should resume once subject is set. Subjects that are unable to maintain the testing procedure for a minimum of **five seconds** at the start are assigned the highest possible score, ten, for that testing condition.

**OPTION:** For further assessment, the same 3 stances can be performed on a surface of medium density foam (e.g., approximately 50 cm x 40 cm x 6 cm).

**Tandem Gait[6,7]**

*Participants are instructed to stand with their feet together behind a starting line (the test is best done with footwear removed). Then, they walk in a forward direction as quickly and as accurately as possible along a 38mm wide (sports tape), 3 meter line with an alternate foot heel-to-toe gait ensuring that they approximate their heel and toe on each step. Once they cross the end of the 3m line, they turn 180 degrees and return to the starting point using the same gait. A total of 4 trials are done and the best time is retained. Athletes should complete the test in 14 seconds. Athletes fail the test if they step off the line, have a separation between their heel and toe, or if they touch or grab the examiner or an object. In this case, the time is not recorded and the trial repeated, if appropriate.*

## Coordination Examination

**Upper limb coordination**

Finger-to-nose (FTN) task:

*"I am going to test your coordination now. Please sit comfortably on the chair with your eyes open and your arm (either right or left) outstretched (shoulder flexed to 90 degrees and elbow and fingers extended), pointing in front of you. When I give a start signal, I would like you to perform five successive finger to nose repetitions using your index finger to touch the tip of the nose, and then return to the starting position, as quickly and as accurately as possible."*

**Scoring: 5 correct repetitions in < 4 seconds = 1**
**Note for testers:** Athletes fail the test if they do not touch their nose, do not fully extend their elbow or do not perform five repetitions. **Failure should be scored as 0.**

## References & Footnotes


1. This tool has been developed by a group of international experts at the 4th International Consensus meeting on Concussion in Sport held in Zurich, Switzerland in November 2012. The full details of the conference outcomes and the authors of the tool are published in The BJSM Injury Prevention and Health Protection, 2013, Volume 47, Issue 5. The outcome paper will also be simultaneously co-published in other leading biomedical journals with the copyright held by the Concussion in Sport Group, to allow unrestricted distribution, providing no alterations are made.

2. McCrory P et al., Consensus Statement on Concussion in Sport – the 3rd International Conference on Concussion in Sport held in Zurich, November 2008. British Journal of Sports Medicine 2009; 43: i76-89.

3. Maddocks, DL; Dicker, GD; Saling, MM. The assessment of orientation following concussion in athletes. Clinical Journal of Sport Medicine. 1995; 5(1): 32–3.

4. McCrea M. Standardized mental status testing of acute concussion. Clinical Journal of Sport Medicine. 2001; 11: 176–181.

5. Guskiewicz KM. Assessment of postural stability following sport-related concussion. Current Sports Medicine Reports. 2003; 2: 24–30.

6. Schneiders, A.G., Sullivan, S.J., Gray, A., Hammond-Tooke, G. & McCrory, P. Normative values for 16-37 year old subjects for three clinical measures of motor performance used in the assessment of sports concussions. Journal of Science and Medicine in Sport. 2010; 13(2): 196–201.

7. Schneiders, A.G., Sullivan, S.J., Kvarnstrom. J.K., Olsson, M., Yden. T. & Marshall, S.W. The effect of footwear and sports-surface on dynamic neurological screening in sport-related concussion. Journal of Science and Medicine in Sport. 2010; 13(4): 382–386

# ATHLETE INFORMATION

**Any athlete suspected of having a concussion should be removed from play, and then seek medical evaluation.**

## Signs to watch for

Problems could arise over the first 24–48 hours. The athlete should not be left alone and must go to a hospital at once if they:

- Have a headache that gets worse
- Are very drowsy or can't be awakened
- Can't recognize people or places
- Have repeated vomiting
- Behave unusually or seem confused; are very irritable
- Have seizures (arms and legs jerk uncontrollably)
- Have weak or numb arms or legs
- Are unsteady on their feet; have slurred speech

**Remember, it is better to be safe.**
**Consult your doctor after a suspected concussion.**

## Return to play

Athletes should not be returned to play the same day of injury.
When returning athletes to play, they should be **medically cleared and then follow a stepwise supervised program,** with stages of progression.

**For example:**

| Rehabilitation stage | Functional exercise at each stage of rehabilitation | Objective of each stage |
|---|---|---|
| No activity | Physical and cognitive rest | Recovery |
| Light aerobic exercise | Walking, swimming or stationary cycling keeping intensity, 70 % maximum predicted heart rate. No resistance training | Increase heart rate |
| Sport-specific exercise | Skating drills in ice hockey, running drills in soccer. No head impact activities | Add movement |
| Non-contact training drills | Progression to more complex training drills, eg passing drills in football and ice hockey. May start progressive resistance training | Exercise, coordination, and cognitive load |
| Full contact practice | Following medical clearance participate in normal training activities | Restore confidence and assess functional skills by coaching staff |
| Return to play | Normal game play | |

There should be at least 24 hours (or longer) for each stage and if symptoms recur the athlete should rest until they resolve once again and then resume the program at the previous asymptomatic stage. Resistance training should only be added in the later stages.

If the athlete is symptomatic for more than 10 days, then consultation by a medical practitioner who is expert in the management of concussion, is recommended.

**Medical clearance should be given before return to play.**

## Scoring Summary:

| Test Domain | Score | | |
|---|---|---|---|
| | Date: | Date: | Date: |
| Number of Symptoms of 22 | | | |
| Symptom Severity Score of 132 | | | |
| Orientation of 5 | | | |
| Immediate Memory of 15 | | | |
| Concentration of 5 | | | |
| Delayed Recall of 5 | | | |
| **SAC Total** | | | |
| BESS (total errors) | | | |
| Tandem Gait (seconds) | | | |
| Coordination of 1 | | | |

## Notes:

# CONCUSSION INJURY ADVICE

(To be given to the **person monitoring** the concussed athlete)

This patient has received an injury to the head. A careful medical examination has been carried out and no sign of any serious complications has been found. Recovery time is variable across individuals and the patient will need monitoring for a further period by a responsible adult. Your treating physician will provide guidance as to this timeframe.

**If you notice any change in behaviour, vomiting, dizziness, worsening headache, double vision or excessive drowsiness, please contact your doctor or the nearest hospital emergency department immediately.**

**Other important points:**

- Rest (physically and mentally), including training or playing sports until symptoms resolve and you are medically cleared
- No alcohol
- No prescription or non-prescription drugs without medical supervision. Specifically:
  - No sleeping tablets
  - Do not use aspirin, anti-inflammatory medication or sedating pain killers
- Do not drive until medically cleared
- Do not train or play sport until medically cleared

**Clinic phone number**

Patient's name

Date/time of injury

Date/time of medical review

Treating physician

Contact details or stamp

# Asthma Policy

## Policy on athletes with asthma:

The National Athletic Trainers' Association defines asthma as "a chronic inflammatory disorder of the airways characterized by variable airway obstruction and bronchial hyper responsiveness." Triggers to asthma are listed on the following pages along with signs and symptoms, and management.

*The following lists are not all-inclusive. An athlete may experience, some, all, or none*

**Asthma triggers:**

- Allergens
  - Pollens
  - Dust mites
  - Animal dander
- Pollutants
  - Carbon dioxide
  - Smoke
  - Ozone
- Respiratory infections
- Aspirin
- Nonsteroidal anti-inflammatory drugs (NSAIDs)
- Inhaled irritants
  - Cigarette smoke
  - Household cleaning fumes
  - Chlorine
- Exposure to cold
- Exposure to exercise

**Signs and Symptoms:**

- Chest tightness
- Chest pain
- Coughing (especially at night)
- Prolonged shortness of breath
- Difficulty sleeping
- Wheezing
- Inability to catch one's breath
- Breathing difficulties
- Family history

**Management:**

- All athletes with asthma should have a rescue inhaler available during all practices and games
- The Certified athletic trainer on duty must have an extra rescue inhaler for emergency use
- Athletes with asthma should have routine follow-up examinations with their primary care physician or specialist to monitor and alter therapy at least every 6-12 months

# Heat Illness Policy

## Heat Illness Policy:

The National Athletic Trainers' Associate (NATA) defines external heat illnesses as exercise-associated muscle cramps, heat syncope, heat exhaustion, exertional heat injury, and/or exertional heat stroke (please see the definitions on the following pages). This policy will define the exertional heat illnesses, as well as the recommended prevention, recognition, and treatment from the NATA.

**Exercise- associated muscle cramps:**

*Definition:* "sudden or sometimes progressively and noticeable evolving, involuntary, painful contractions of skeletal muscle during or after exercise."

*Signs and symptoms:* visible cramping, localized pain, dehydration, thirst, sweating or fatigue

*Treatment:* rest, passive static stretching, ice, massage, sodium containing fluids

**Heat syncope:**

*Definition:* orthostatic dizziness

*Signs and symptoms:* brief period of fainting, dizziness, tunnel vision, pale/ sweaty skin, decreased pulse

*Treatment:* move patient to shaded area, monitor vitals, elevate legs above heart, cool skin, rehydrate

**Heat exhaustion:**

*Definition:* "the inability to effectively exercise in the heat, secondary to a combination of factors, including cardiovascular insufficiency, hypotension, energy depletion, and central fatigue."

*Signs and symptoms:* excessive fatigue, fainting, collapsing, headache, dizziness, confusion

*Treatment:* remove any excess clothing & equipment, move patient to cool, shaded area, cool body, monitor vital signs, place patient in supine position with legs elevated above heart, fluid replacement, if no recovery within 30 min contact EMS

**Exertional heat injury:**

*Definition:* "moderate to severe heat illness characterized by organ (e.g. liver, renal) and tissue (e.g. gut, muscle) injury associated with sustained high body temperature resulting from strenuous exercise and environmental heat

exposure. Body temperature is usually but not always greater than 40.5ºC (105ºF)."

*Signs and symptoms:* end-organ damage, no altered mental status, very dark, cola colored urine

**Exertional heat stroke:**

*Definition*: "the most severe heat illness. It is characterized by neuropsychiatric impairment and a high core body temperature, typically > 40.5ºC (105ºF)."

*Signs and symptoms:* altered mental status, core body temperature greater than 40.5ºC (105ºF)

*Treatment:* CONTACT EMS!!!!, lower core body temperature to < 102ºF within 30 min, immerse body in pool/ tub of cold water (35ºF), remove excess clothing and equipment

*****Temperature will not be taken with a rectal thermometer. Therefore, Heat illnesses will be based on signs and symptoms.**

**Athlete must be completely cooled before transport by EMS. EMS is not permitted to transfer the athlete until he or she is at a stable condition.**

**Prevention:**

1. Conduct thorough Pre Participation Exams prior to the start of the season and identify athletes with risk factors
2. Heat acclimatization in first 2-3 weeks of the season
3. No participation for athletes who are currently sick
4. Athletes should maintain proper hydration
5. All staff must be educated on preventing and recognizing heat illness
6. Medical care must be available at all times
7. Cold- water or ice tub should be available when conditions warrant heat illnesses
8. Encourage athletes to sleep at least 7 hours / night in a cool environment
9. Identify individuals high susceptible to heat illness
10. Plan water/ rest breaks throughout practice

# Diabetes Policy

## Policy on Type 1 Diabetes

According to the National Athletic Trainers' Association, "the primary goal of diabetes management is to consistently maintain blood glucose levels in a normal or near-normal range without provoking undue hypoglycemia." Any athlete that is diagnosed with diabetes should have a diabetes care plan in place. An example of a diabetes care plan is provided in the following pages. It is important to monitor athletes with diabetes for hypoglycemia, hyperglycemia and ketosis. Travel tips are also included on the following pages.

**Ranges of Glucose:**

| *Test* | *Normal* | *Pre-Diabetes* | *Diabetes* |
|---|---|---|---|
| *Random plasma glucose* | **70- 126 mg/dL** | **127 to 199 mg/dL** | **≥ 200 mg/dL with symptoms** |
| *Fasting plasma glucose* | **70 to 100 mg/ dL** | **100 to 125 mg/ dL** | **≥ 126 mg/dL with symptoms** |
| *2 hours after eating* | **100 to 140 mg/ dL** | **>140 mg/dL** | **> 140 mg/dL** |
| *Oral glucose tolerance test* | **<140 mg/dL** | **140 to 199 mg/dL** | **≥ 200 mg/dL** |

**Example of Diabetes Care Plan:**

- blood glucose monitoring guidelines
  - frequency of monitoring
- insulin therapy guidelines
  - type of insulin used
  - dosages
  - adjustment strategies
- list of other medications
- guidelines for hypoglycemia recognition and treatment
  - prevention
  - s/s
  - treatment
    - use of glucagon
- guidelines for hyperglycemia recognition and treatment
  - prevention
  - s/s
  - treatment
- emergency contact information
  - parents/ guardians phone numbers
  - physician phone number
  - consent for medical treatment (minors)
- medic alert tag with them at all times

## Hypoglycemia:

- blood glucose < 70 mg/dL
- sudden onset
- headache
- hunger but no thirst
- blurred vision
- dizziness
- decreased performance
- increased heart rate
- fatigue
- slurred speech
- confusion

### Fast action carbohydrates to help treat hypoglycemia:

| *Snack Item* | *Quantity* |
|---|---|
| *Glucagon Gel* | Follow instructions on label for quantity that provides 15g |
| *Glucagon tablets* | Follow instructions on label for quantity that provides 15g |
| *Apple or orange juice* | 4 ounces (0.1kg) (1.2 C) |
| *Raisins* | 2 tablespoons |
| *Sugar or honey* | 1 tablespoon |

## Hyperglycemia and ketosis:

- blood glucose > 200 mg/dL
- gradual onset
- abdominal pain
- thirst but not hunger
- fruity odor on breath
- dehydration
- lethargy
- confusion
- loss of consciousness

## Travel Recommendations:

- carry pre-packaged meals and snacks
- have a medical identification bracelet
- have a copy of the diabetes care plan

# Communicable Disease Policy

## Communicable Disease Policy

This policy is set in place to protect and prevent the employees, students, and visitors of Benjamin Franklin High School. Communicable diseases can be spread from person to person or animal to person through fluid contact or airborne bacteria. Anyone who is noted to have a communicable disease must have proper documentation maintain with the athletic trainer and the office. This includes the affected person's name, disease, and when medical treatment was sought. If a person, employee, or student has a diagnosis of one of the diseases on the following page, he or she should be removed from the facility IMMEDIATELY. They must seek treatment and document the treatment. They will be allowed to return once they are cleared by a physician. Anyone who has been in contact with the affected person must be notified and follow the appropriate treatment procedures.

**List of Communicable Diseases:**

- HIV/ AIDS
- Chickenpox
- Chronic fatigue syndrome
- Common cold
- Diphtheria
- E. Coli
- Giardiasis
- Infectious mononucleosis
- Influenza (Flu)
- Lyme disease
- Malaria
- Measles
- Meningitis
- Mumps
- Poliomyelitis (polio)
- Pneumonia
- Rocky mountain spotted fever
- Rubella (German measles)
- Salmonella infections
- Severe acute respirator syndrome (SARS)
- Sexually transmitted diseases
- Shingles (herpes zoster)
- Tetanus
- Toxic shock syndrome
- Tuberculosis
- Viral hepatitis overview
- West nile virus
- Whooping cough (pertussis)

# Modalities Policy

## Modalities:

### Cryotherapy:

*Indications:*
Sprains
Strains
Contusions
Muscle spasm

*Contraindications:*
Circulatory disturbances
Hypersensitivity to cold
Placement over superficial nerves

*Therapeutic Effects:*
Pain reduction through an anesthetic effect
Reduction in swelling and inflammation
Decrease in muscle spasm by slowing nerve conduction to muscles

*Treatment Techniques:*

Ice Packs:
- Crushed/ shaved ice for conforming
- Treatment time: approximately 20 min per hour

Ice Immersion:
- Tap water with Ice (12.8/ 53ºF)
- Treatment time: 15-20 minutes

### Hydrotherapy:

*Indications:*
Ongoing treatment of:
Sprains
Strains
Contusions
Muscle spasm
Tendonitis
Tenosynovitis
To assist in increasing Range of Motion (ROM) after surgery or immobilization

*Contraindications*:
Warm or hot whirlpool with acute injury, hemorrhaging or swelling
Impaired or deficient thermal sensation
Impaired or deficient thermoregulatory control

*Therapeutic and Physiological Effects:*
Sedative and analgesic action
Reduction of muscle spasm
Stimulating action on circulation

# Bloodborne Pathogen Policy

## Personal Protective Equipment (PPE):

- PPE will be provided by the athletic trainer if needed
- PPE must be removed before leaving the contaminated area OR once a PPE becomes contaminated
- Used PPE must be placed in designated Biohazard Bags
- Gloves must be worn at all times when managing blood or other potential infections materials
- Disposable gloves must never be reused

## Housekeeping:

- All equipment and surfaces will be disinfected once they have been contaminated with blood or other potential infections materials
- Broken glass must be picked up with tongs or a broom and dust pan only. DO NOT PICK UP GLASS OR OTHER SHARP MATERIALS WITH YOUR HANDS!!!
- All infections materials will be placed in the appropriate biohazard bags
- All sharp materials will be placed in the appropriate sharps container located in the nurse's office in the high school

## Labeling:

- All infections waste containers will be labeled appropriately with the biohazard symbol and the word biohazard

## Exposure Procedure:

- The method of exposure will be documented
- The infected individual will be identified and documented
- The infected individual will be required to seek further blood testing to determine if they have been exposed to HIV, HBV, HCV or any other bloodborne pathogen
- The athletic trainer must be notified of any athletes or employees that may become infected to document

# Football/ Soccer Field Specific

## In case of emergency on the soccer/ football field

In the event of an emergency situation on the soccer/ football field, the following protocols should be followed:

- The athletic trainer is the first responder and will be in charge of medical emergencies
    - Please see “in case of athletic trainer absence” for information on what to do in that scenario
- Jeremy Strong will be responsible for retrieving the AED from the weight room
- Head coach will be responsible for calling 911 and providing the appropriate information listed under “emergency contact information”
    - Directions to the field:
        - EMS will meet one student at the entrance
        - She will direct them to the field
        - EMS will meet another student at the gate, where she will direct them to the injury

# Baseball Field Specific

## In case of emergency on the baseball field

In the event of an emergency situation on the baseball field, the following protocols should be followed:

- The athletic trainer is the first responder and will be in charge of medical emergencies
    - Please see “in case of athletic trainer absence” for information on what to do in that scenario
- Jeremy Strong will be responsible for retrieving the AED from the weight room
- Head coach will be responsible for calling 911 and providing the appropriate information listed under “emergency contact information”
    - Directions to the field:
        - EMS will meet designated person at the entrance
        - He/ she will direct them to the field
        - EMS will meet designated personnel at the gate, where he/she will direct them to the injury

# Softball Field Specific

## In case of emergency on the softball field

In the event of an emergency situation on the softball field, the following protocols should be followed:

- The athletic trainer is the first responder and will be in charge of medical emergencies
    - Please see “in case of athletic trainer absence” for information on what to do in that scenario
- Jeremy Strong will be responsible for retrieving the AED from the weight room
- Head coach will be responsible for calling 911 and providing the appropriate information listed under “emergency contact information”
    - Directions to the field:
        - EMS will meet designated person at the entrance
        - He/ she will direct them to the field
        - EMS will meet designated personnel at the gate, where he/she will direct them to the injury

# Gym specific

## In case of emergency in the gym

In the event of an emergency situation in the gym, the following protocols should be followed:

- The athletic trainer is the first responder and will be in charge of medical emergencies
    - Please see “in case of athletic trainer absence” for information on what to do in that scenario
- Jeremy Strong will be responsible for retrieving the AED from the weight room
- Head coach will be responsible for calling 911 and providing the appropriate information listed under “emergency contact information”
    - Directions to the field:
        - EMS will meet designated person at the road
        - He/ she will direct them to the front entrance of the school
        - EMS will meet designated personnel at the door, where he/she will direct them to the gym

# References

## References:


1. Broglio SP, et all. National Athletic Trainers' Association Position Statement: Management of Sport Concussion. *J Athl Train*. 2014; 49(2): 245- 265.
2. Casa DJ, et all. National Athletic Trainers' Association Position Statement: Exertional Heat Illness. *J Athl Train*. 2015; 50(9): 986- 1000.
3. Jimenez CC, et all. National Athletic Trainers' Association Position Statement: management of the athlete with type 1 diabetes mellitus. *J Athl Train*. 2007; 42(4): 536- 545.
4. Miller MG, Weiler JM, Baker R, Collins J and D'Alonzo G. National Athletic Trainer's Association Position Statement: Management of Asthma in Athletes. *J Athl Train*. 2005; 40(3): 224-245.
5. O'Connor DP and Fincher AL. *Clinical Pathology for Athletic Trainers*. Thorofare, NJ: SLACK Incorporated; 2015.
6. Occupational Safety and Health Administration. Best Practices Guide: Fundamentals of a Workplace First Aid Program. 2015. Available at: https://www.osha.gov/Publications/OSHA3317first-aid.pdf. Accessed July 24, 2016.
7. Occupational Safety and Health Administration. Compliance Assistance Quick Start | Health Care Industry. 2015. Available at: https://www.osha.gov/dcps/compliance_assistance/quickstarts/health_care/index_hc.html. Accessed July 24, 2016.
8. Occupational Safety and Health Administration. Principal Emergency Response and Preparedness: Requirements and Guidance. 2015. Available at: https://www.osha.gov/publications/osha3122.pdf. Accessed July 24, 2016.
9. Walsh, KM et all. National Athletic Trainers' Associate Position Statement: Lightning Safety for Athletic and Recreation. *J Athl Train*. 2013; 48(2): 258- 270.