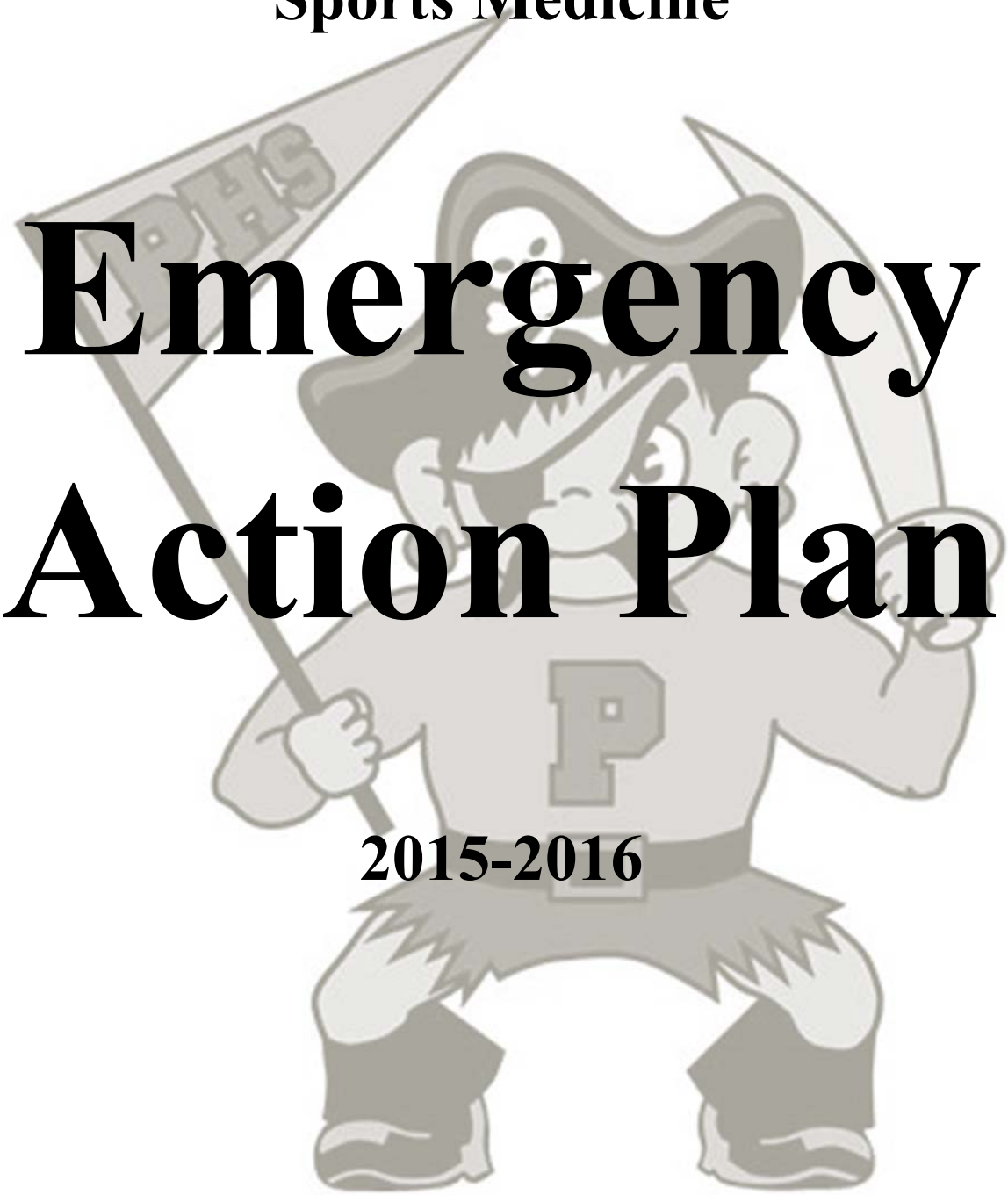
Palatine High School

Sports Medicine



Emergency Action Plan

2015-2016

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Palatine High School Sports Medicine

Mission

The Palatine High School Athletic Training Staff is committed to provide the highest quality sports medicine services to its student-athletes by providing injury prevention, assessment, and care as well as rehabilitation and emergency services.

Athletic Training Staff

Name	Title	Season
Katie O'Keefe	Head Athletic Trainer	F, W, S, Summer
Tyler Austin	Assistant Athletic Trainer	F, W, S
Amy Brault	Assistant Athletic Trainer	F
Jennifer Garofalo	Assistant Athletic Trainer	W
Athletico Employee	Assistant Athletic Trainer	S

Team Physicians

Barrington Orthopedics: Tom Obermeyer, MD Fall 2015
Midwest Bone and Joint: James Seeds, MD

Team Physical Therapists

Athletico Physical Therapy

Policies

Practice for Injured Athletes

Athletes will be encouraged to attend practice after their treatment/rehabilitation. When possible, athletes will participate in modified activity during practice.

Physician Referral

Athletes with orthopedic injuries needing evaluation by a physician will be referred to an orthopedic specialist. Athletes must return a note from their physician to the athletic training staff prior to any return to participation or treatments/rehabilitation in the athletic training room.

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Pre-Participation Physical Exams

Student-athletes are required to have a pre-participation physical on file with the school nurse.

Heat Illness

The Athletic Training staff will monitor and discuss scheduled water breaks with the coaching staff. Education of proper nutrition and acclimatization will be provided to all student-athletes.

Concussion

Baseline ImPACT testing will be required for football, cross country, volleyball, swimming & diving, tennis, gymnastics, water polo, golf, wrestling, basketball, bowling, track, badminton, soccer, lacrosse, softball, baseball, pom dance team, cheerleading, and flag team. All student-athletes will be baseline tested the first season of participation and every two years following. Baseline ImPACT testing must occur prior to the first competition. Injuries will follow the concussion and head injury policy and procedure.

Communication of Injured Athletes

Student-athlete injuries will be communicated to coaches by e-mail, phone, PHS athletic training room note or face-to-face conversation. Initial participation status of athletes will be communicated by a written note given to the student-athlete to present to their coach. If there are any questions or concerns the coach should follow-up with the athletic training staff. Student-athlete confidentiality must be maintained. Injuries will be documented in Infinite Campus when an elevator pass and physical education adjustments are needed.

Emergency Plan

Emergency Action Plan will be reviewed by the PHS Athletic Training staff, athletic director, and coaches prior to each year.

Weather

The athletic training staff and athletic director are responsible for monitoring the weather. Appropriate coaches will be informed by the athletic director with specific practice modifications. The athletic administration will make the decision on athletic event modification due to the weather. The Mid Suburban League weather guidelines will be followed by the athletic training staff and coaches.

Palatine High School Sports Medicine
Emergency Action Plan

Introduction

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

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

Components of an Emergency Plan

1. Emergency Personnel
2. Emergency Communication
3. Emergency Equipment
4. Roles of First Responder
5. Venue Directions with a Map
6. Emergency Action Plan Checklist for Non-Medical Emergencies

Emergency Plan Personnel

With athletic 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. A team physician may not always 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 instance may be a coach or other institutional personnel. Certification in cardiopulmonary resuscitation (CPR), first aid, prevention of disease transmission, and emergency plan review is strongly recommended for all athletics personnel associated with practices, competitions, skills instruction, and strength and conditioning.

The development of an emergency plan cannot be completed 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, student athletic trainers, coaches, parents, and, possibly, other bystanders. Roles of these individuals within the emergency team may vary depending on various factors such as the number of members of the team, the athletic venues itself, or the preferences of the head athletic trainer. There are four basic roles within the emergency team. The first and most important role is establishing safety of the scene

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

Roles within the Emergency Team:

1. Establish scene safety and immediate care of the athlete
2. Activation of Emergency Medical Services
3. Emergency Equipment Retrieval
4. Direction of EMS to the Scene

Activating the EMS System

Making the Call:

9-1-1

Providing Information

- Name, address, telephone number of caller
- Nature of emergency
- Number of athletes
- Condition of athlete(s)
- First aid treatment initiated by ATC/Physician scene
- Other information as requested by dispatcher

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

Emergency Communication

Communication is the key to quick emergency response. Athletic trainers and emergency medical personnel must work together to provide the best emergency response capability and should have contact information such as telephone tree established as a part of pre-planning for emergency situations. Communication prior to the event is a good way to establish boundaries and

to build rapport between both groups of professionals. If emergency medical transportation is not available on site during a particular sporting event then direct communication with the emergency medical system at the time of injury or illness is necessary.

Access to a working telephone or other telecommunications devices, whether fixed or mobile, should be assured. The communication system should be checked prior to each practice or competition to ensure proper working order. A back-up communication plan should be in effect should there be failure of the primary communication system. The most common method of communication is a public telephone, however, 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. Pre-arranged access to the phone should be established if it is not easily accessible.

Emergency Equipment

All necessary emergency equipment should be at the site and quickly accessible. Personnel should be familiar with the function and operation of each type of emergency equipment. Equipment should be in a good operating condition, and personnel must be trained in advance to use it properly. The emergency equipment available should be appropriate for the level of training for the emergency medical providers. The school's Certified Athletic Trainers should be trained and responsible for the care of the medical equipment. It is important to know the proper way to care for and store the equipment as well. Equipment should be stored in a clean and environmentally controlled area. It should be available when emergency situations arise.

Medical Emergency Transportation

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

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

Non-Medical Emergencies

For the non-medical emergencies (fire, bomb threats, violent or criminal behavior, etc.) refer to the school emergency action plan checklist and follow instructions.

Conclusion

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

Approval and Acceptance of the Palatine High School Emergency Plan for Athletics

Approved by: _____ _____
Palatine High School Team Physician Date

Approved by: _____ _____
Palatine High School Athletics Director Date

Approved by: _____ _____
Palatine High School Head Athletic Trainer Date

Approved by: _____ _____
Palatine High School Asst. Athletic Trainer Date

Approved by: _____ _____
Palatine High School Asst. Athletic Trainer Date

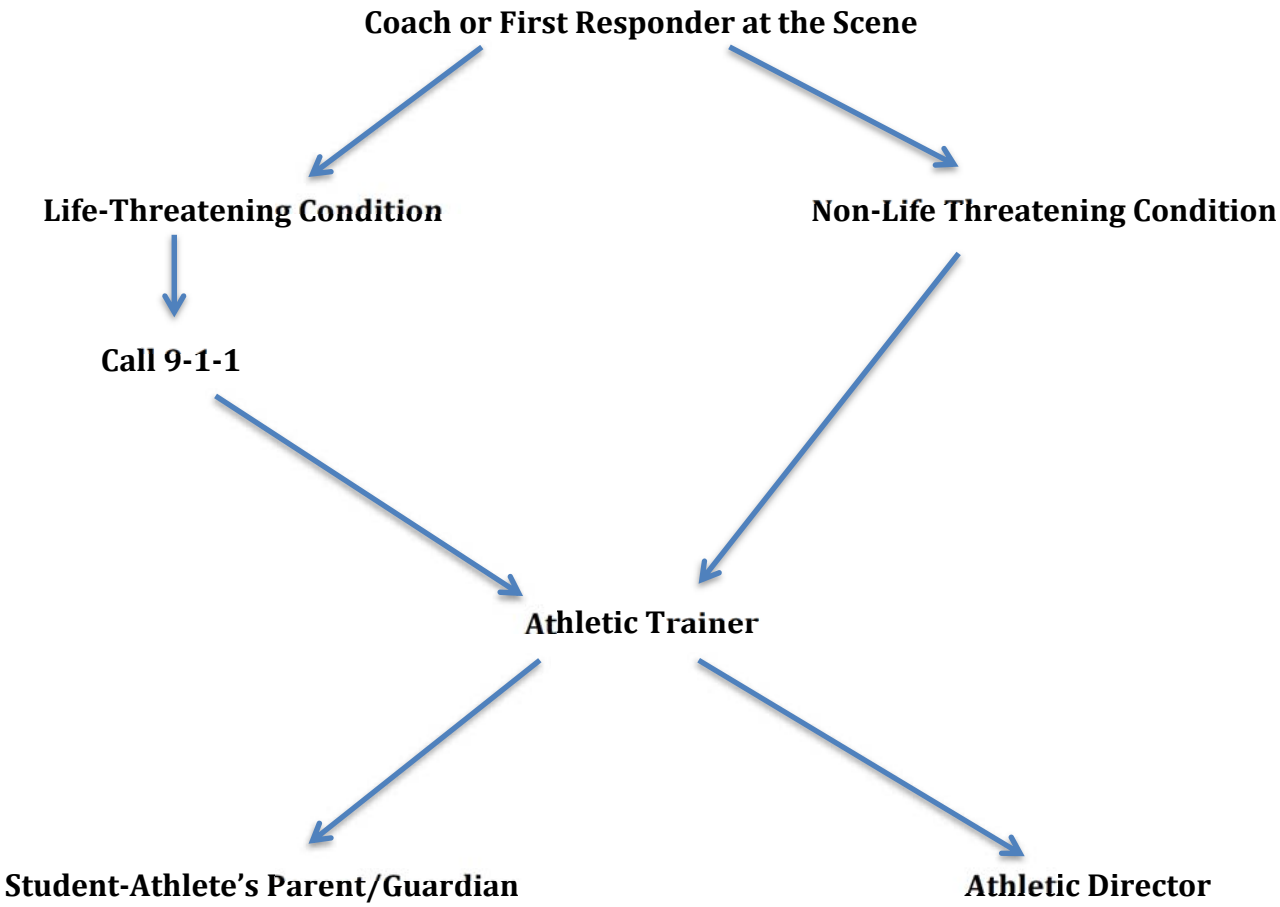
Emergency Contact List

On Campus Office	Phone Number
Athletic Training Room	(847) 755- 1790
Athletic Office	(847) 755- 1770
Main Office	(847) 755- 1600
Nurse's Office	(847)755-1662

Title	Name	Office	Cell
Athletic Director	Jerry Dobbs	(847) 755-1770	(847)922-0252
Head Athletic Trainer	Katie O'Keefe	(847) 755-1790	(515) 720-5700
Assistant Athletic Trainer	Tyler Austin	(847) 755-1790	(847) 769-4655
Assistant Athletic Trainer	Amy Brault	(847) 755-1790	(773) 550-3741
Assistant Athletic Trainer	Jennifer Garofalo	(847) 755-1790	(630) 921-1471

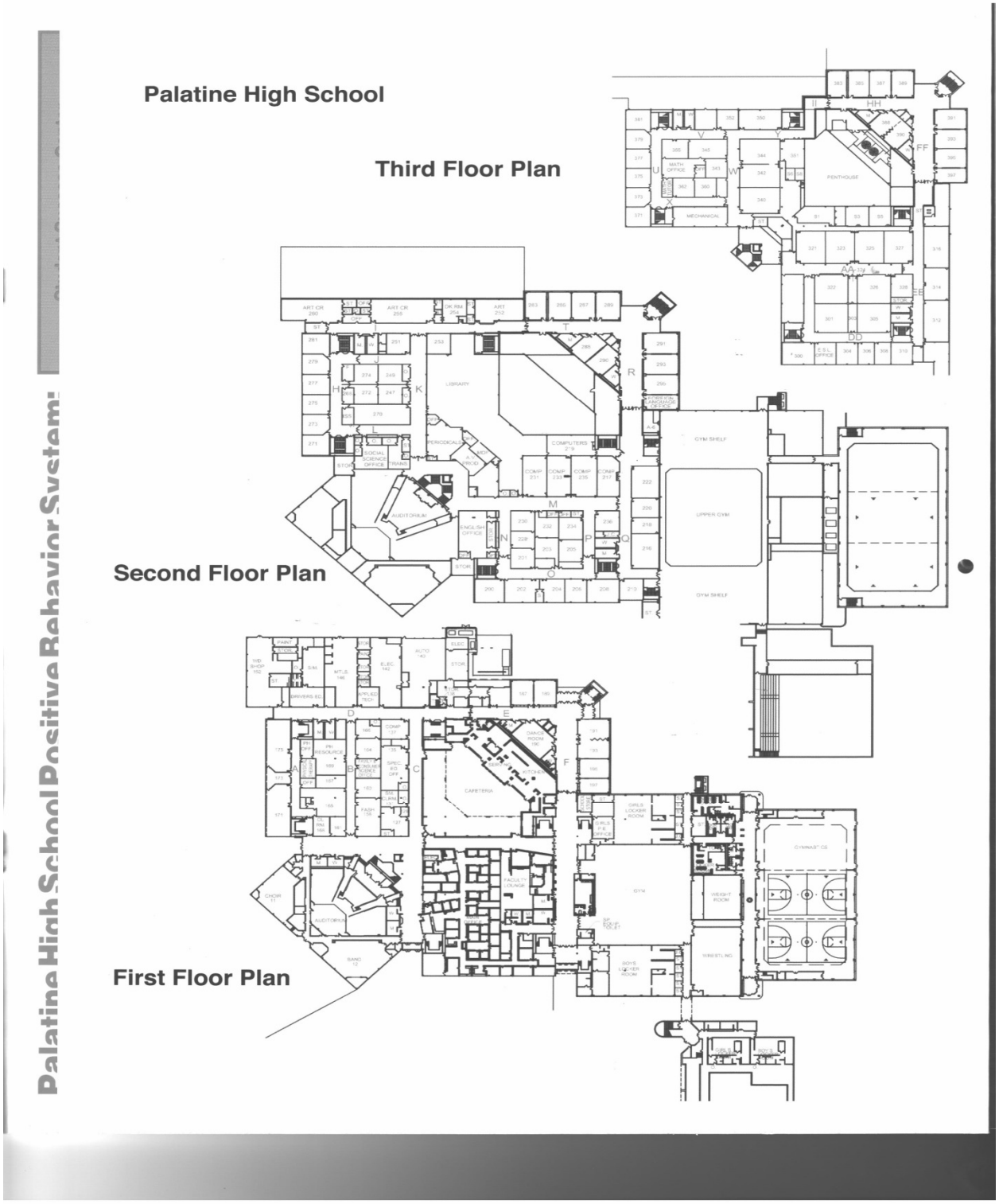
Off Campus Contact	Phone Number
Palatine Village Police Department (non-emergency)	(847) 359-9000
Palatine Village Fire Department (non-emergency)	(847) 359-9000
Northwest Community Hospital	(847) 618-1000
Poison Control Center	1 800 222-1222

Accident/Injury Contact Phone Tree

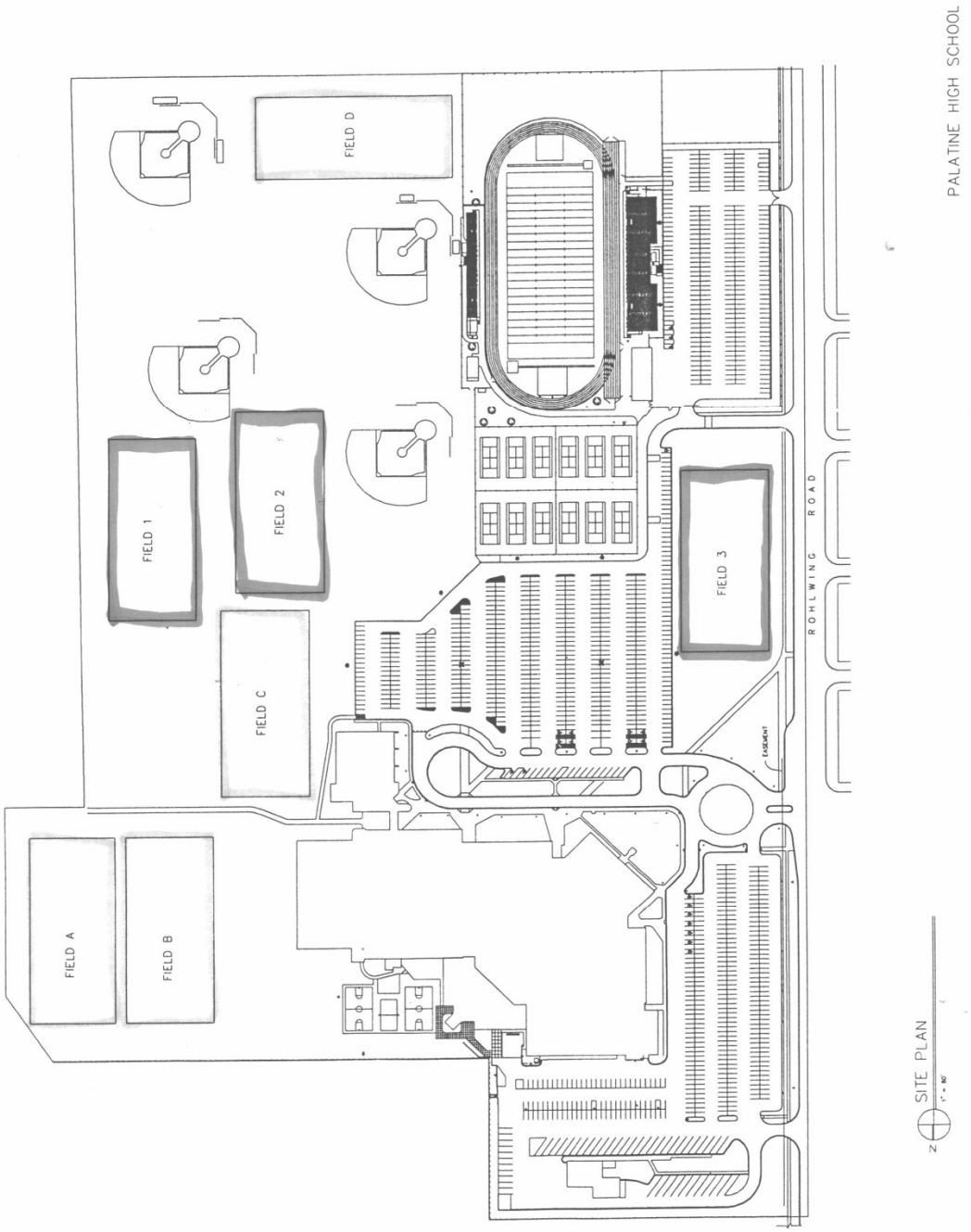


* **Note:** This is a basic plan. Please use professional judgment when a student-athlete is injured. Move down the chart if you are unable to reach the appropriate staff member.

Indoor Campus Map



Outdoor Campus Map

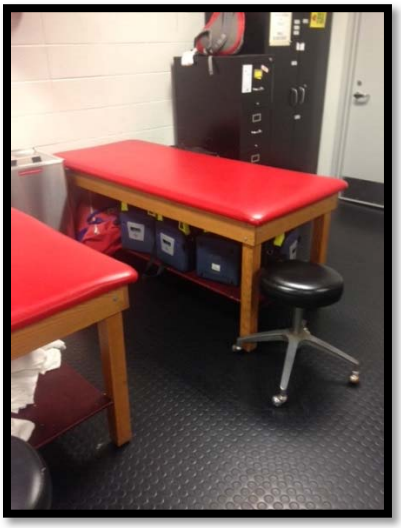


Mounted AED Locations

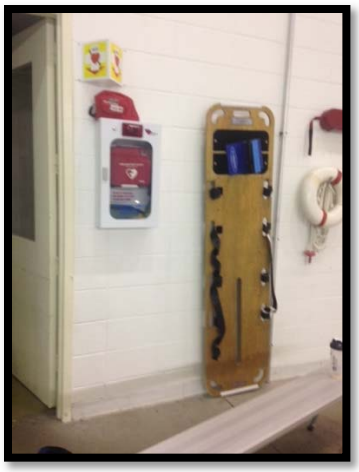
Indoor:

1) Main Gym: Next to wrestling room doors

2) Athletic Training room: Under last table closest to storage closet



3) Pool: Outside of boys pool office



Outdoor:

4) Field B: On outside wall of East Gym

5) Varsity Softball: On baseball outfield fence, between softball and baseball fields

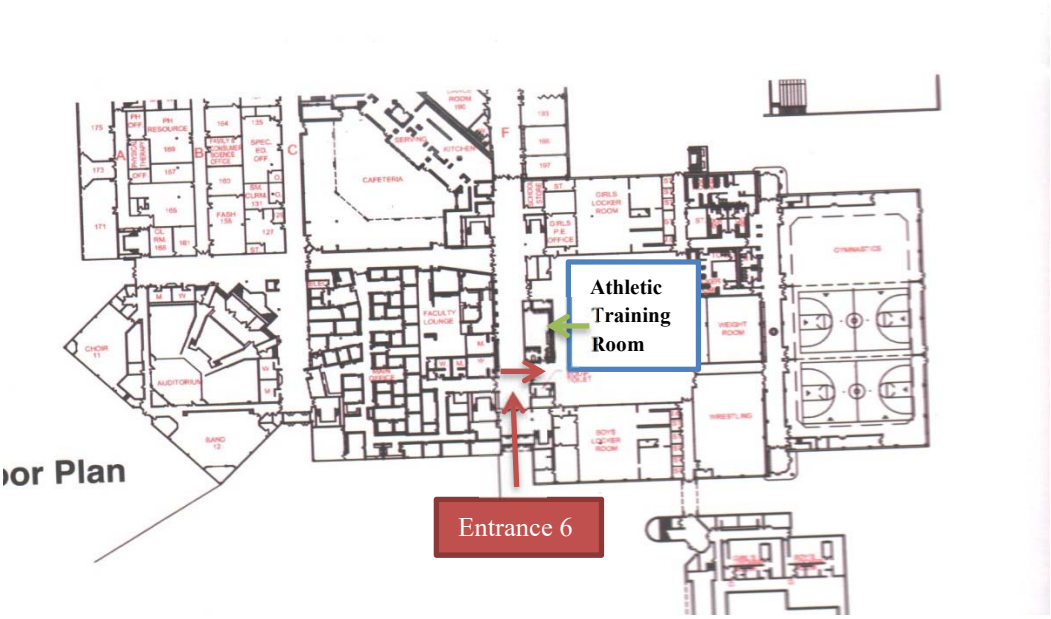
6) Stadium: Outer wall of visitor concussion stand

7) Stadium: Outer wall of home concussion stand

Athletic Training Room EAP

Address: 1111 N. Rohlwing Road, Palatine, IL 60074

Venue Directions: Venue is accessible through Entrance 6 located on the South side of Palatine High School. Follow the hallway straight and turn right at the first set of doors into the main gymnasium. The Athletic Training room is located right inside the doors to the main gymnasium on the left.



Emergency Personnel: Certified athletic trainer
Emergency Communication:
Radios are located on the shelf above the computer inside the athletic training room. Each certified athletic trainer will have a radio on them. There is a fixed, landline telephone in the office inside the athletic training room.
Athletic Training Room: (847) 755-1790

Emergency Equipment:
AED is located under the last table closest to storage closest in the back of the Athletic Training room. Other emergency equipment is located inside the Athletic Training room.

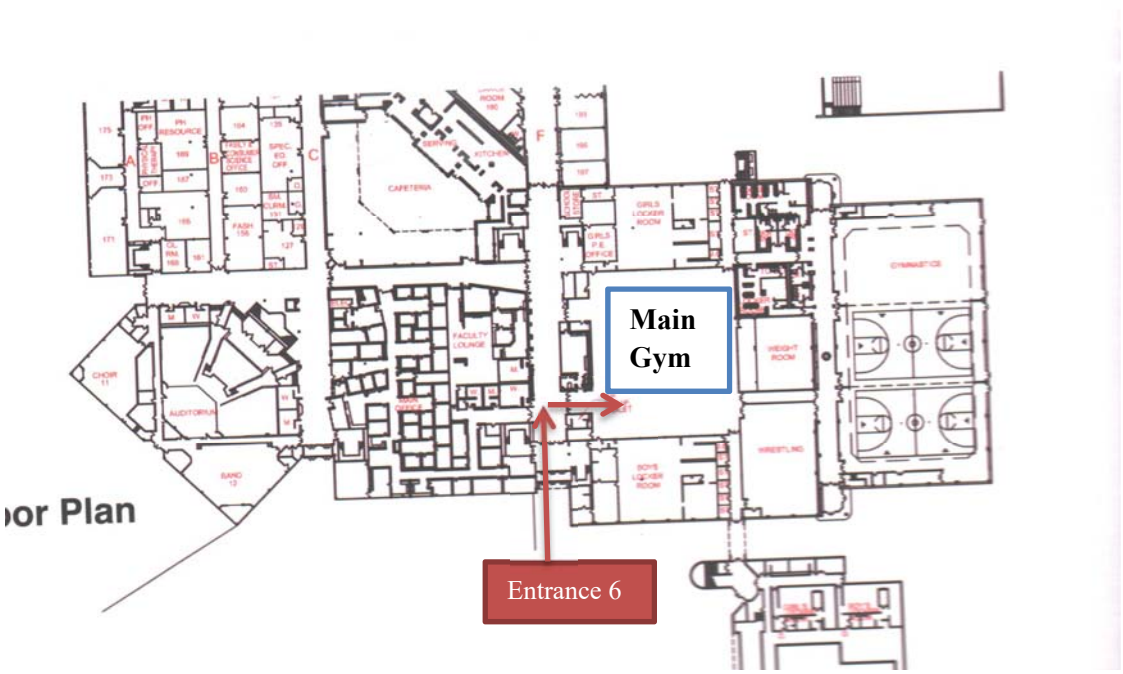
Role of First Responder:

1. Immediate care of injured or ill student-athlete.
2. Activation of emergency medical services (EMS)
    a. Call 9-1-1
    b. Activate phone tree
3. Emergency equipment retrieval
4. Direct EMS to scene
    a. Open appropriate doors
    b. Designate individual to “flag down” EMS and direct to scene
    c. Scene control: Limit scene to first aid providers and move bystanders away from area

Gymnasium EAP

Address: 1111 N. Rohlwing Road, Palatine, IL 60074

Venue Directions: Venue is accessible through Entrance 6 on the south side of the school. Follow the hallway down past the first set of doors and turn right through the next set of doors.



Emergency Personnel: Certified athletic trainer
Emergency Communication: Each certified athletic trainer will have a radio on them. There is a fixed, landline telephone in the office inside the athletic training room. Athletic Training Room: (847) 755-1790. Athletic Trainer will be present at all competitions and radio will be at the scorer's table during competition.

Emergency Equipment:
AED is located in the main gymnasium next to wrestling doors. Another AED is located Athletic Training room. Other emergency equipment is located inside the athletic training room. For contests there will be an AED with Athletic Trainer

Role of First Responder:

1. Immediate care of injured or ill student-athlete.
2. Activation of emergency medical services (EMS)
    a. Call 9-1-1
    b. Activate phone tree
3. Emergency equipment retrieval
4. Direct EMS to scene
    a. Open appropriate doors
    b. Designate individual to "flag down" EMS and direct to scene
    c. Scene control: Limit scene to first aid providers and move bystanders away from area

East Gymnasium EAP

Address: 1111 N. Rohlwing Road, Palatine, IL 60074

Venue Directions: Venue is accessible through Entrance 6 on the south side of Palatine High School. Follow the hallway down past the first set of doors and turn right through the next set of doors towards the main gymnasium. Pass through the main gymnasium and through two sets of double doors. The east gymnasium will be straight ahead.

Emergency Personnel: Certified athletic trainer

Emergency Communication: Each certified athletic trainer will have a radio on them. There is a fixed, landline telephone in the office inside the athletic training room. Athletic Training Room: (847) 755-1790. Athletic Trainer will be present at all competitions and radio will be at the scorer's table during competition.

Emergency Equipment:

AED is located in the main gymnasium next to wrestling doors. Another AED is located Athletic Training room. Other emergency equipment is located inside the athletic training room. For contests there will be an AED with Athletic Trainer

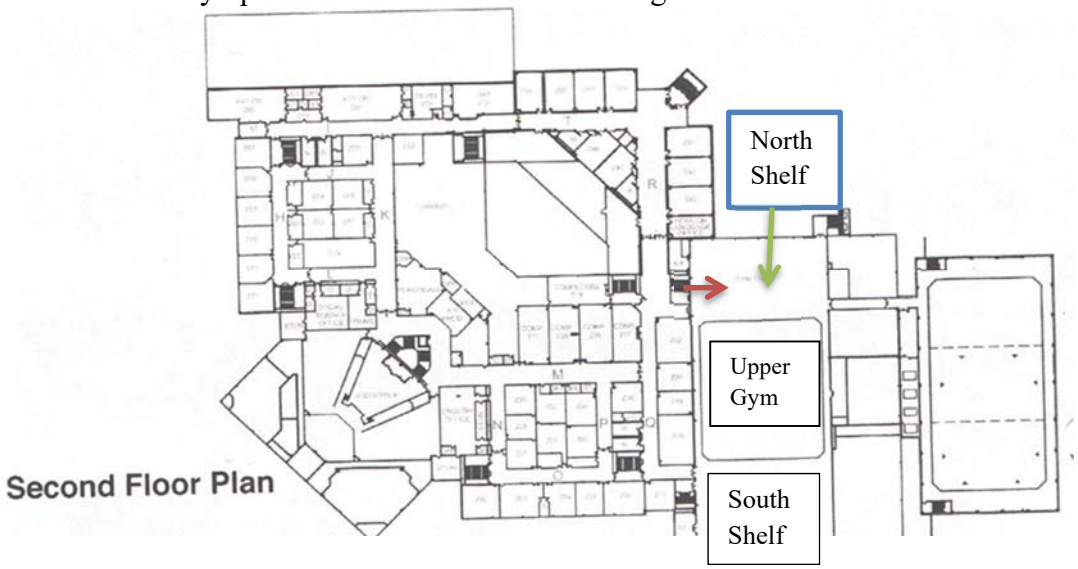
Role of First Responder:

1. Immediate care of injured or ill student-athlete.
2. Activation of emergency medical services (EMS)
   a. Call 9-1-1
   b. Activate phone tree
3. Emergency equipment retrieval
4. Direct EMS to scene
   a. Open appropriate doors
   b. Designate individual to "flag down" EMS and direct to scene
   c. Scene control: Limit scene to first aid providers and move bystanders away from area

North Shelf EAP

Address: 1111 N. Rohlwing Road, Palatine, IL 60074

Venue Directions: Venue is accessible through Entrance 6 near main gymnasium. Follow the hallway down past the main gymnasium. There will be a set of stairs on the right side. Take the stairs all the way up and enter the north shelf through a set of double doors.



Emergency Personnel: Certified athletic trainer

Emergency Communication: Each certified athletic trainer will have a radio on them. There is a fixed, landline telephone in the office inside the athletic training room. Athletic Training Room: (847) 755-1790. Athletic Trainer will be present at all competitions and radio will be at the scorer's table during competition.

Emergency Equipment:
AED is located in the main gymnasium next to wrestling doors. Another AED is located Athletic Training room. Other emergency equipment is located inside the athletic training room. For contests there will be an AED with Athletic Trainer.

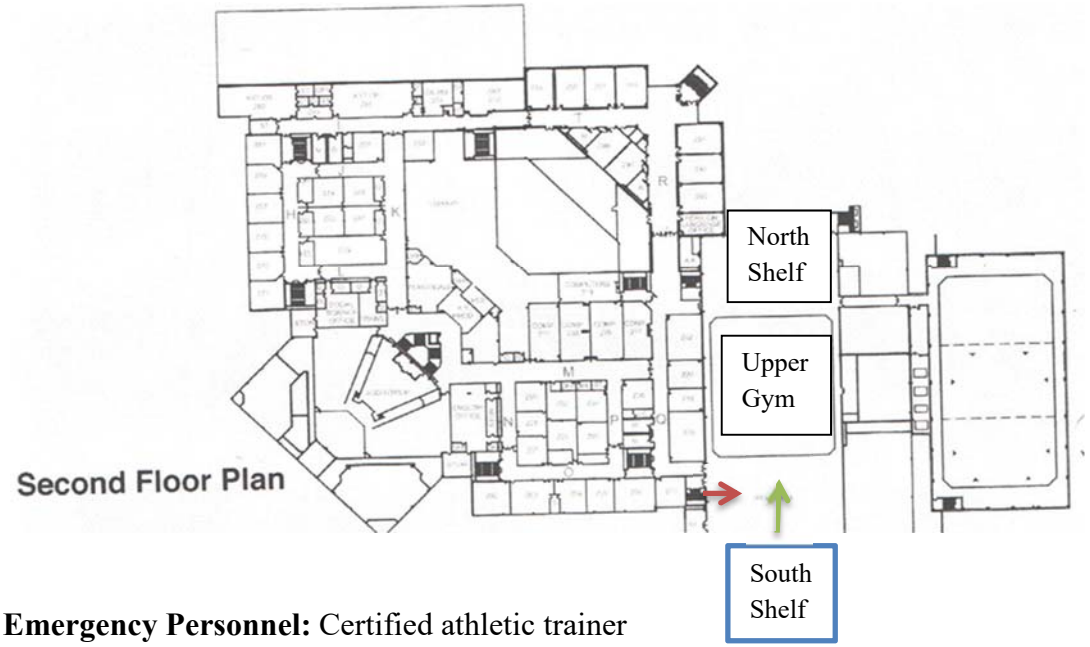
Role of First Responder:

1. Immediate care of injured or ill student-athlete.
2. Activation of emergency medical services (EMS)
   a. Call 9-1-1
   b. Activate phone tree
3. Emergency equipment retrieval
4. Direct EMS to scene
   a. Open appropriate doors
   b. Designate individual to "flag down" EMS and direct to scene
   c. Scene control: Limit scene to first aid providers and move bystanders away from area

South Shelf EAP

Address: 1111 N. Rohlwing Road, Palatine, IL 60074

Venue Directions: Venue is accessible through Entrance 6 near main gymnasium. Follow the hallway down through the first set of double doors. Take the stair case to the right after entering the school. Follow the stairs all the way up and through the doors to the south shelf.



Emergency Personnel: Certified athletic trainer
Emergency Communication: Each certified athletic trainer will have a radio on them. There is a fixed, landline telephone in the office inside the athletic training room. Athletic Training Room: (847) 755-1790. Athletic Trainer will be present at all competitions and radio will be at the scorer's table during competition.

Emergency Equipment:
AED is located in the main gymnasium next to wrestling doors. Another AED is located Athletic Training room. Other emergency equipment is located inside the athletic training room. For contests there will be an AED with Athletic Trainer

Role of First Responder:

1. Immediate care of injured or ill student-athlete.
2. Activation of emergency medical services (EMS)
   a. Call 9-1-1
   b. Activate phone tree
3. Emergency equipment retrieval
4. Direct EMS to scene
   a. Open appropriate doors
   b. Designate individual to "flag down" EMS and direct to scene
   c. Scene control: Limit scene to first aid providers and move bystanders away from area

Wrestling Room EAP

Address: 1111 N. Rohlwing Road, Palatine, IL 60074

Venue Directions: Venue is accessible through Entrance 6 on the south side of Palatine High School. Follow the hallway down past the first set of doors and turn right through the next set of doors towards the main gymnasium. Pass through the main gymnasium and the wrestling doors will be on the right along the east wall of the main gymnasium.

Emergency Personnel: Certified athletic trainer
Emergency Communication: Each certified athletic trainer will have a radio on them. There is a fixed, landline telephone in the office inside the athletic training room. Athletic Training Room: (847) 755-1790. Athletic Trainer will be present at all competitions and radio will be at the scorer's table during competition.

Emergency Equipment:
AED is located in the main gymnasium next to wrestling doors. Another AED is located Athletic Training room. Other emergency equipment is located inside the athletic training room. For contests there will be an AED with Athletic Trainer

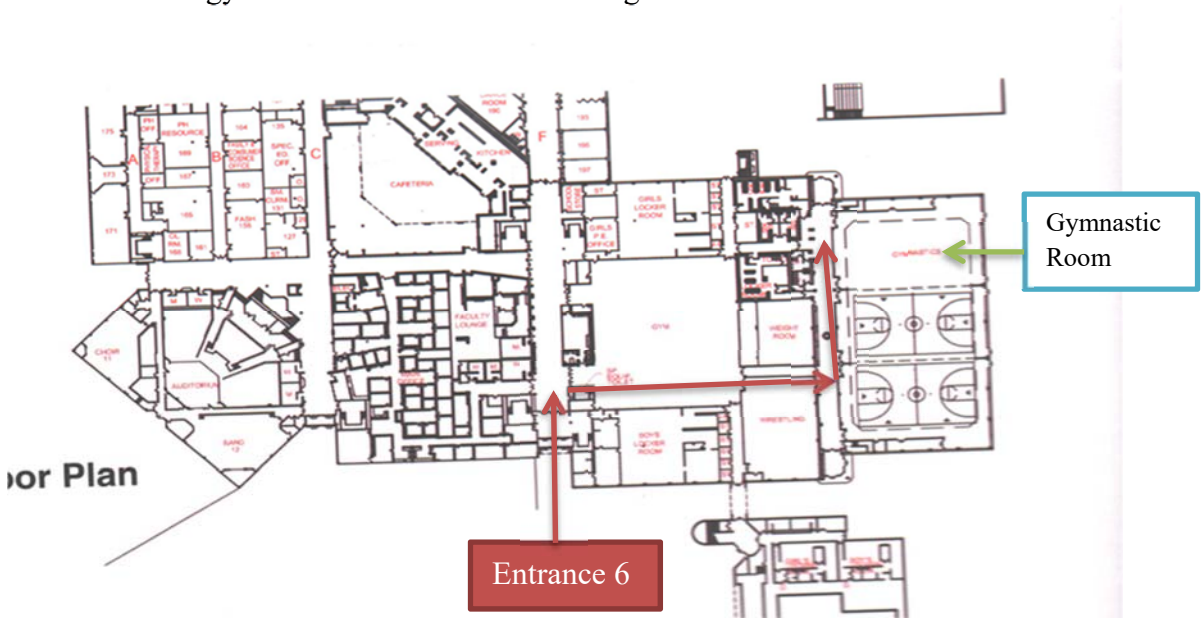
Role of First Responder:

1. Immediate care of injured or ill student-athlete.
2. Activation of emergency medical services (EMS)
   a. Call 9-1-1
   b. Activate phone tree
3. Emergency equipment retrieval
4. Direct EMS to scene
   a. Open appropriate doors
   b. Designate individual to "flag down" EMS and direct to scene
   c. Scene control: Limit scene to first aid providers and move bystanders away from area

Gymnastics Room EAP

Address: 1111 N. Rohlwing Road, Palatine, IL 60074

Venue Directions: Venue is accessible through Entrance 6 on the south side of Palatine High School. Follow the hallway down past the first set of doors and turn right through the next set of doors towards the main gymnasium. Pass through the main gymnasium and through two sets of double doors. Turn left into the back hallway. Follow the back hallway all the way down to entrance 7. The gymnastic room will be on the right side.



Emergency Personnel: Certified athletic trainer

Emergency Communication: Each certified athletic trainer will have a radio on them. There is a fixed, landline telephone in the office inside the athletic training room. Athletic Training Room: (847) 755-1790. Athletic Trainer will be present at all competitions and radio will be at the scorer's table during competition.

Emergency Equipment:

AED is located in the main gymnasium next to wrestling doors. Another AED is located Athletic Training room. Other emergency equipment is located inside the athletic training room. For contests there will be an AED with Athletic Trainer

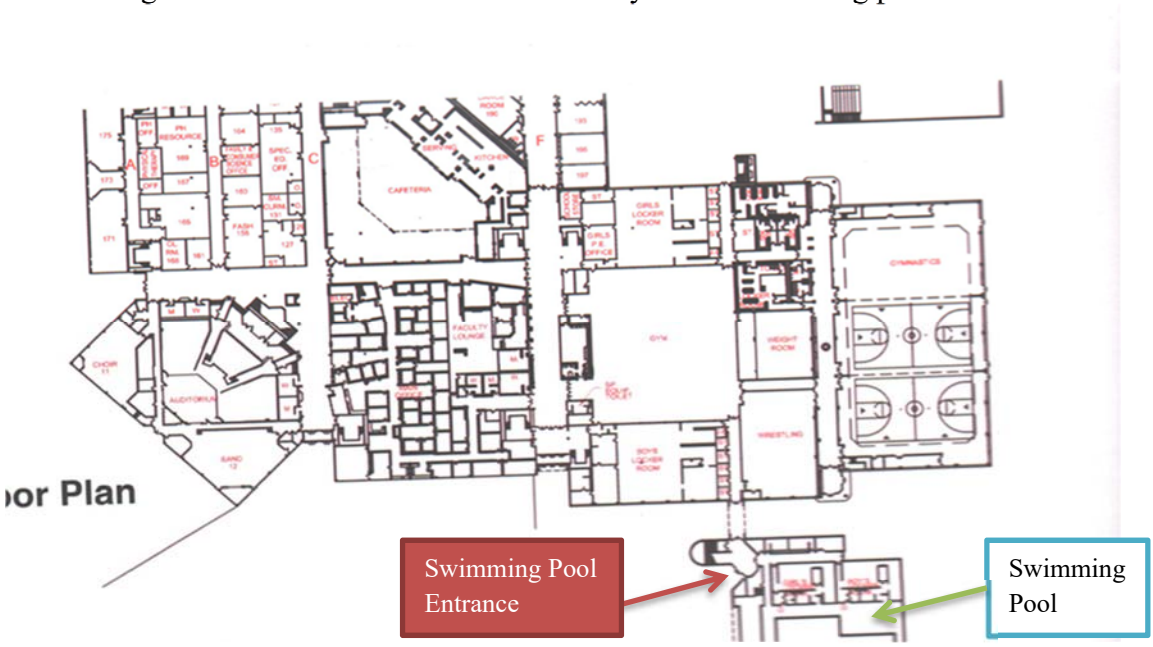
Role of First Responder:

1. Immediate care of injured or ill student-athlete.
2. Activation of emergency medical services (EMS)
   a. Call 9-1-1
   b. Activate phone tree
3. Emergency equipment retrieval
4. Direct EMS to scene
   a. Open appropriate doors
   b. Designate individual to "flag down" EMS and direct to scene
   c. Scene control: Limit scene to first aid providers and move bystanders away from area

Swimming Pool EAP

Address: 1111 N. Rohlwing Road, Palatine, IL 60074

Venue Directions: Venue is accessible through swimming pool entrance near the south side of Palatine High School. Follow the circle drive way to the swimming pool entrance.



Emergency Personnel: Certified athletic trainer
Emergency Communication: Each certified athletic trainer will have a radio on them. There is a fixed, landline telephone in the office inside the athletic training room. Athletic Training Room: (847) 755-1790. Athletic Trainer will be present at all competitions and radio will be at the scorer's table during competition.

Emergency Equipment:
AED is located on the north wall of the swimming pool next to the boy's locker room. All other emergency equipment is located in the Athletic Training room.

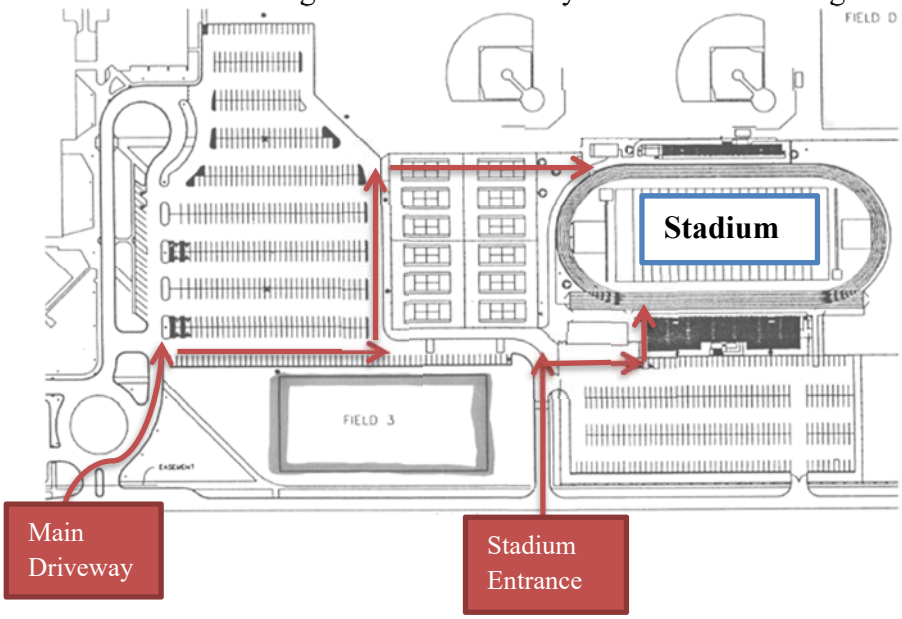
Role of First Responder:

1. Immediate care of injured or ill student-athlete.
2. Activation of emergency medical services (EMS)
   a. Call 9-1-1
   b. Activate phone tree
3. Emergency equipment retrieval
4. Direct EMS to scene
   a. Open appropriate doors
   b. Designate individual to "flag down" EMS and direct to scene
   c. Scene control: Limit scene to first aid providers and move bystanders away from area

Stadium EAP

Address: 1111 N. Rohlwing Road, Palatine, IL 60074

Venue Directions: Venue is accessible through Stadium entrance off of Rohlwing Road. Venue is also accessible through the main driveway entrance and cutting across the parking lot.



Emergency Personnel: Certified athletic trainer
Emergency Communication: Each certified athletic trainer will have a radio on them. There is a fixed, landline telephone in the office inside the athletic training room. Athletic Training Room: (847) 755-1790. Athletic Trainer will be present at all competitions and radio will be at the scorer's table during competition.

Emergency Equipment:
There are two AEDs located at the main stadium of Palatine High School. One is located on the visitor concession stand, on the east side of the stadium. The second AED is located on the home concession stand on the west side of the stadium.

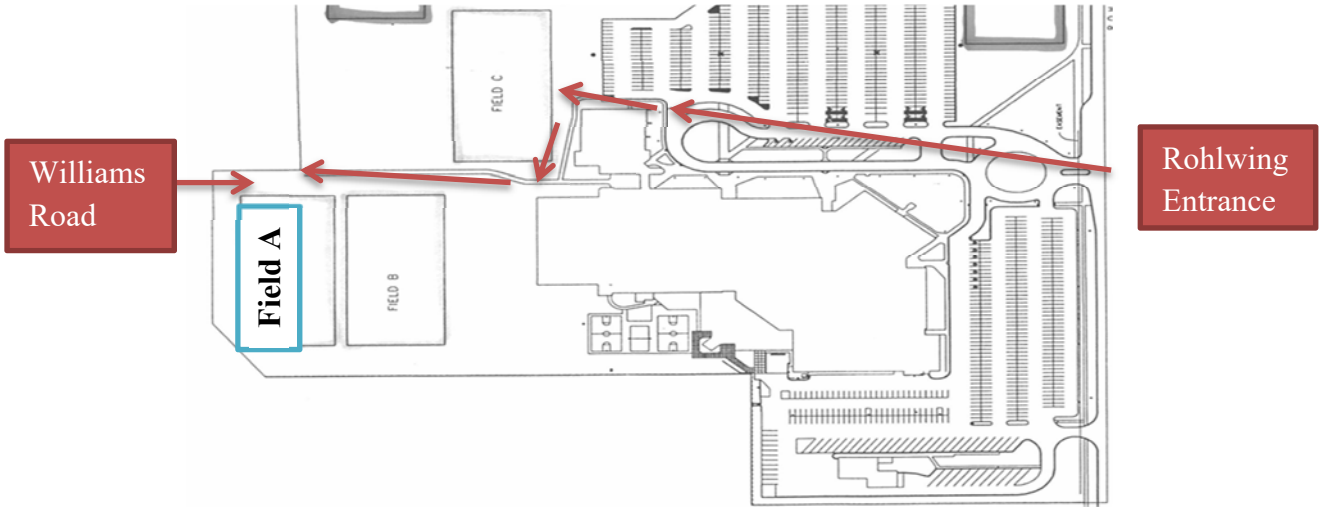
Role of First Responder:

1. Immediate care of injured or ill student-athlete.
2. Activation of emergency medical services (EMS)
   a. Call 9-1-1
   b. Activate phone tree
3. Emergency equipment retrieval
4. Direct EMS to scene
   a. Open appropriate doors
   b. Designate individual to "flag down" EMS and direct to scene
   c. Scene control: Limit scene to first aid providers and move bystanders away from area

Field A EAP

Address: 1111 N. Rohlwing Road, Palatine, IL 60074

Venue Directions: Venue is accessible through the main school entrance off of Rohlwing Road. There is also an access gate off of Rand Road and Williams Road.



Emergency Personnel: Certified athletic trainer

Emergency Communication: Each certified athletic trainer will have a radio on them. There is a fixed, landline telephone in the office inside the athletic training room. Athletic Training Room: (847) 755-1790. Athletic Trainer will be present at all competitions and radio will be at the scorer's table during competition.

Emergency Equipment:
There is a mounted AED on the outside wall of the East Gymnasium. An AED will be available for all practices and competitions. All other emergency equipment is located inside the athletic training room.

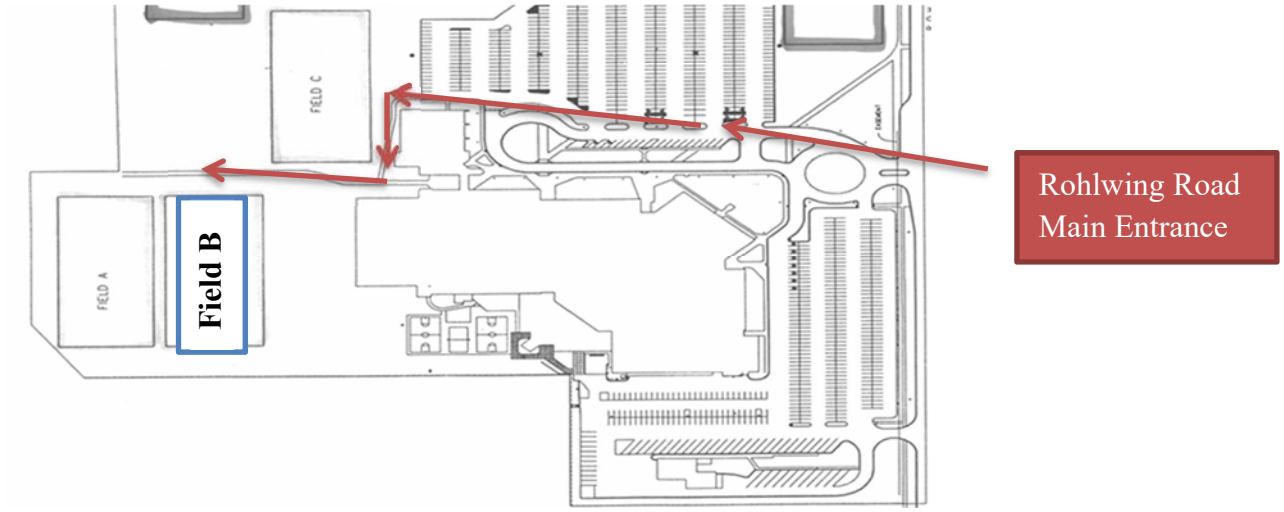
Role of First Responder:

1. Immediate care of injured or ill student-athlete.
2. Activation of emergency medical services (EMS)
    a. Call 9-1-1
    b. Activate phone tree
3. Emergency equipment retrieval
4. Direct EMS to scene
    a. Open appropriate doors
    b. Designate individual to "flag down" EMS and direct to scene
    c. Scene control: Limit scene to first aid providers and move bystanders away from area

Field B EAP

Address: 1111 N. Rohlwing Road, Palatine, IL 60074

Venue Directions: Venue is accessible through the main school entrance off of Rohlwing Road. Pass through the main parking lot to the back entrance gate. There is a paved path that can be taken to field A & B.



Emergency Personnel: Certified athletic trainer

Emergency Communication: Each certified athletic trainer will have a radio on them. There is a fixed, landline telephone in the office inside the athletic training room. Athletic Training Room: (847) 755-1790. Athletic Trainer will be present at all competitions and radio will be at the scorer's table during competition.

Emergency Equipment:
There is a mounted AED on the outside wall of the East Gymnasium. An AED will be available for all practices and competitions. All other emergency equipment is located inside the athletic training room.

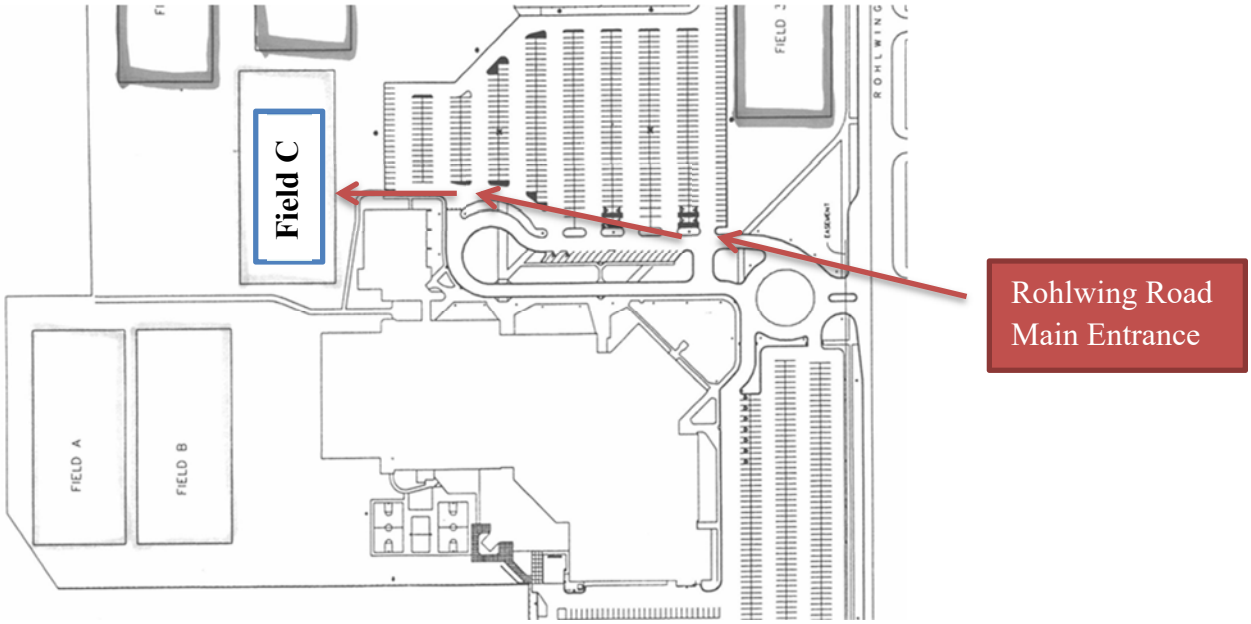
Role of First Responder:

1. Immediate care of injured or ill student-athlete.
2. Activation of emergency medical services (EMS)
   a. Call 9-1-1
   b. Activate phone tree
3. Emergency equipment retrieval
4. Direct EMS to scene
   a. Open appropriate doors
   b. Designate individual to "flag down" EMS and direct to scene
   c. Scene control: Limit scene to first aid providers and move bystanders away from area.

Field C EAP

Address: 1111 N. Rohlwing Road, Palatine, IL 60074

Venue Directions: Venue is accessible through the main school entrance off of Rohlwing Road. Pass through the main parking lot to the back entrance gate.



Emergency Personnel: Certified athletic trainer

Emergency Communication: Each certified athletic trainer will have a radio on them. There is a fixed, landline telephone in the office inside the athletic training room. Athletic Training Room: (847) 755-1790. Athletic Trainer will be present at all competitions and radio will be at the scorer's table during competition.

Emergency Equipment:
There is a mounted AED on the outside wall of the East Gymnasium. An AED will be available for all practices and competitions. All other emergency equipment is located inside the athletic training room.

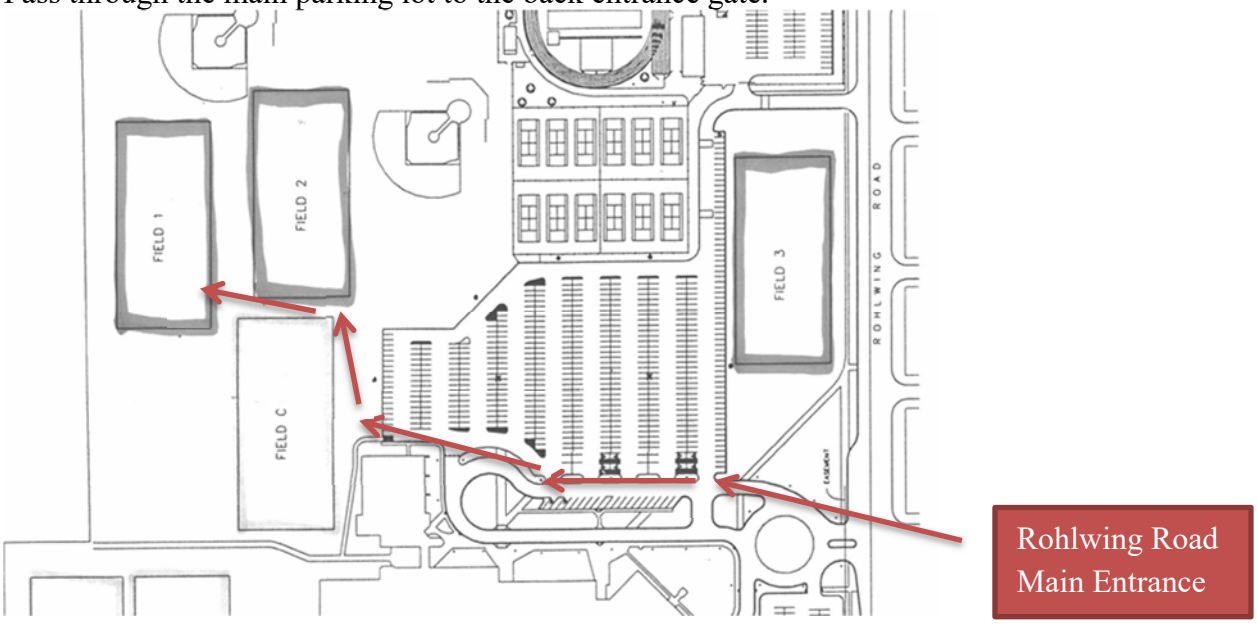
Role of First Responder:

1. Immediate care of injured or ill student-athlete.
2. Activation of emergency medical services (EMS)
   a. Call 9-1-1
   b. Activate phone tree
3. Emergency equipment retrieval
4. Direct EMS to scene
   a. Open appropriate doors
   b. Designate individual to "flag down" EMS and direct to scene
   c. Scene control: Limit scene to first aid providers and move bystanders away from area

Field 1 EAP

Address: 1111 N. Rohlwing Road, Palatine, IL 60074

Venue Directions: Venue is accessible through the main school entrance off of Rohlwing Road. Pass through the main parking lot to the back entrance gate.



Emergency Personnel: Certified athletic trainer

Emergency Communication: Each certified athletic trainer will have a radio on them. There is a fixed, landline telephone in the office inside the athletic training room. Athletic Training Room: (847) 755-1790. Athletic Trainer will be present at all competitions and radio will be at the scorer's table during competition.

Emergency Equipment:
There is a mounted AED on the outside wall of the East Gymnasium. An AED will be available for all practices and competitions. All other emergency equipment is located inside the athletic training room.

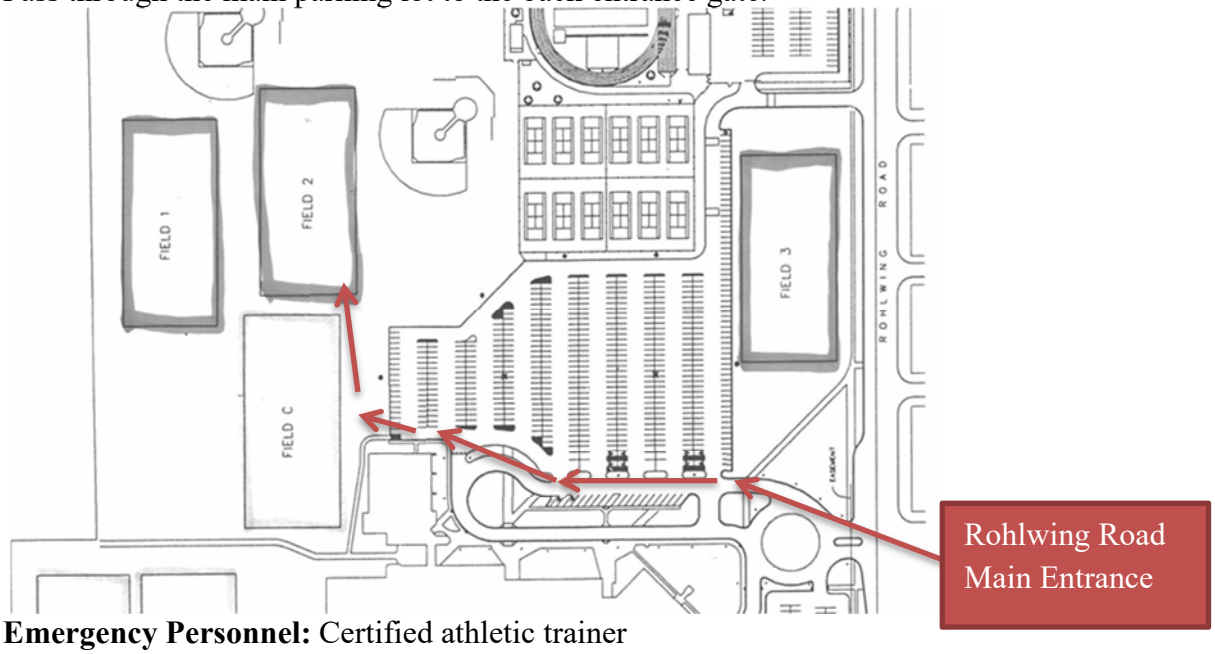
Role of First Responder:

1. Immediate care of injured or ill student-athlete.
2. Activation of emergency medical services (EMS)
    a. Call 9-1-1
    b. Activate phone tree
3. Emergency equipment retrieval
4. Direct EMS to scene
    a. Open appropriate doors
    b. Designate individual to "flag down" EMS and direct to scene
    c. Scene control: Limit scene to first aid providers and move bystanders away from area

Field 2 EAP

Address: 1111 N. Rohlwing Road, Palatine, IL 60074

Venue Directions: Venue is accessible through the main school entrance off of Rohlwing Road. Pass through the main parking lot to the back entrance gate.



Emergency Personnel: Certified athletic trainer

Emergency Communication: Each certified athletic trainer will have a radio on them. There is a fixed, landline telephone in the office inside the athletic training room. Athletic Training Room: (847) 755-1790. Athletic Trainer will be present at all competitions and radio will be at the scorer's table during competition.

Emergency Equipment:
There is a mounted AED on the outside wall of the East Gymnasium. An AED will be available for all practices and competitions. All other emergency equipment is located inside the athletic training room.

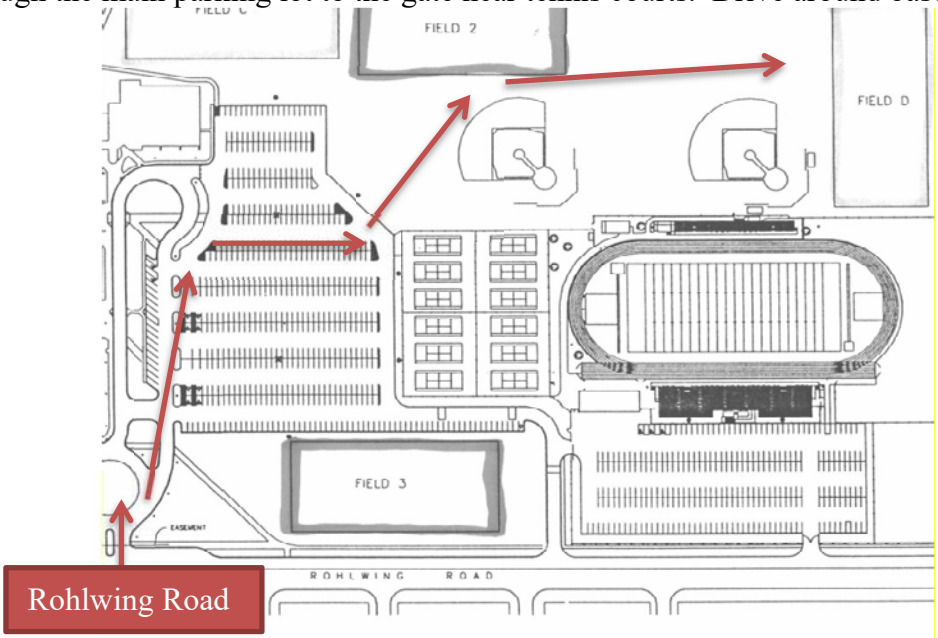
Role of First Responder:

1. Immediate care of injured or ill student-athlete.
2. Activation of emergency medical services (EMS)
   a. Call 9-1-1
   b. Activate phone tree
3. Emergency equipment retrieval
4. Direct EMS to scene
   a. Open appropriate doors
   b. Designate individual to "flag down" EMS and direct to scene
   c. Scene control: Limit scene to first aid providers and move bystanders away from area

Field D EAP

Address: 1111 N. Rohlwing Road, Palatine, IL 60074

Venue Directions: Venue is accessible through the main school entrance off of Rohlwing Road. Pass through the main parking lot to the gate near tennis courts. Drive around baseball fields.



Emergency Personnel: Certified athletic trainer

Emergency Communication: Each certified athletic trainer will have a radio on them. There is a fixed, landline telephone in the office inside the athletic training room. Athletic Training Room: (847) 755-1790. Athletic Trainer will be present at all competitions and radio will be at the scorer's table during competition.

Emergency Equipment:
There is a mounted AED on the fence of the varsity baseball field. An AED will be available for all practices and competitions. All other emergency equipment is located inside the athletic training room.

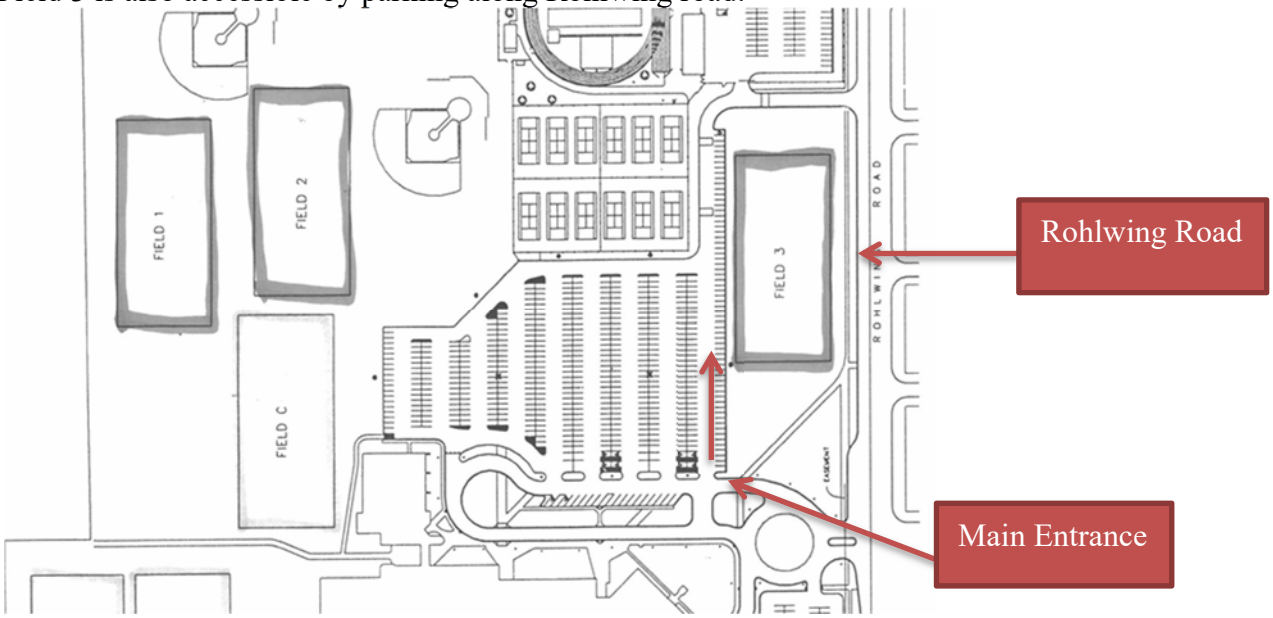
Role of First Responder:

5. Immediate care of injured or ill student-athlete.
6. Activation of emergency medical services (EMS)
   a. Call 9-1-1
   b. Activate phone tree
7. Emergency equipment retrieval
8. Direct EMS to scene
   c. Open appropriate doors
   d. Designate individual to "flag down" EMS and direct to scene
   e. Scene control: Limit scene to first aid providers and move bystanders away from area

Field 3 EAP

Address: 1111 N. Rohlwing Road, Palatine, IL 60074

Venue Directions: Venue is accessible through the main school entrance off of Rohlwing Road. Field 3 is also accessible by parking along Rohlwing road.



Emergency Personnel: Certified athletic trainer

Emergency Communication: Each certified athletic trainer will have a radio on them. There is a fixed, landline telephone in the office inside the athletic training room. Athletic Training Room: (847) 755-1790. Athletic Trainer will be present at all competitions and radio will be at the scorer's table during competition.

Emergency Equipment:
There are two AEDs located at the main stadium of Palatine High School. One is located on the visitor concession stand, on the east side of the stadium. The second AED is located on the home concession stand on the west side of the stadium.

Role of First Responder:

9. Immediate care of injured or ill student-athlete.
10. Activation of emergency medical services (EMS)
    a. Call 9-1-1
    b. Activate phone tree
11. Emergency equipment retrieval
12. Direct EMS to scene
    c. Open appropriate doors
    d. Designate individual to "flag down" EMS and direct to scene
    e. Scene control: Limit scene to first aid providers and move bystanders away from area
    f.

Anaphylaxis Policies and Procedure

Introduction

There currently is not a universally agreed-upon definition of anaphylaxis. The National Institute of Allergy and Infectious Disease and the Food Allergy and Anaphylaxis Network have agreed that "anaphylaxis is a serious allergic reaction that is rapid in onset and may cause death." The European Academy of Allergology and Clinical Immunology Nomenclature Committee proposed the following: "Anaphylaxis is a severe, life-threatening, generalized or hypersensitivity reaction that is characterized by rapidly developing life-threatening airway and/or breathing and/or circulation problems usually associated with skin and mucosal changes."

Recognition of Anaphylaxis

Anaphylaxis may present with sudden and rapid onset of symptoms. The patient may present with airway problems such as airway swelling (throat and tongue), difficulty breathing and swallowing with a feeling that the throat is closing, hoarse voice, and/or stridor. The patient may present with breathing problems such as shortness of breath, wheezing, cyanosis, feeling tired, and/or confusion due to hypoxia. The patient may present circulation problems such as signs of shock (pale, cool, clammy skin), increased pulse, low blood pressure, feeling faint, dizziness, and/or cardiac arrest. The patient may present skin changes such as erythema, uticaria, and/or angioedema (most commonly in the lips, eyelids, mouth and throat).

Management of Anaphylaxis

Allow athlete to utilize their prescribed epi-pen (if they have one). Activate the emergency medical system (EMS). Lie athlete flat with legs elevated. Prepare to utilize AED in the event of cardiac arrest.

References

1. Anderson, J., Courson, R.W., Kleiner, D.M., & McLoda, T.A. (2002). *National Athletic Trainers' Association Position Statement: Emergency Planning in Athletics*. J Athl Train, 37(1), 99-104.

2. Casa, D.J. (2012). *Preventing sudden death in sport and physical activity*. Sudbury, MA: Jones & Bartlett Learning.

Asthma Policies and Procedure

Introduction

Asthma is a chronic inflammatory disorder of the airways characterized by variable airway obstruction and bronchial hyper-responsiveness. Airway obstruction can lead to recurrent episodes of wheezing, breathlessness, chest tightness, and coughing. Asthma currently affects over 300 million individuals worldwide and 20 million Americans, with 5 million being under the age of 18 years. Asthma is the cause of 4200-5000 American deaths per year. The majority of patients with asthma and patients with allergies will have exercise-induced bronchospasm (EIB). EIB usually occurs during or minutes after vigorous activity. EIB reaches its peak 5-10 minutes after stopping the activity and usually resolves in another 20-30 minutes.

Recognition of Asthma

A patient suffering from asthma will present with a peak flow meter less than 80% of their normal value. They can also present with wheezing, chest tightness, respiratory rate greater than 25 breaths per minute, pulse greater than 120 beats per minute, forced expiratory volume in the first second of less than 40%, weak breath sounds, confusion, sweating, drowsiness, low level of oxygen saturation, use of accessory muscle for breathing, cyanosis, coughing, hypotension, bradycardia or tachycardia, mental status changes, inability to lie supine, inability to speak coherently, agitation, and/or unconsciousness.

Management of Asthma

A patient suffering from asthma should utilize their meter-dosed inhaler or other medication as prescribed by their physician. The athletic trainer, coach, and/or first responder should calm down the athlete. Activate EMS if the athlete is breathless or if there is no response to medication in three hours or if there is further deterioration. The athlete should be instructed in proper breathing techniques (breathe in through mouth, out through nose).

Basic Life Support Treatment for Severe Asthma

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

- Call for EMS
- Maintain a patent airway
- Initiate early emergency transport

Asthma Medications

It is the student-athlete's responsibility to carry their asthma medication. A back-up supply can be given to the athletic training staff. Medications will not be shared between student-athletes, and only athletes with a prescription from their physician will be given their medication.

Storage of Asthma Medications

Asthma medication will be stored inside the office in the athletic training room. Medication belonging to student athletes who participate in outdoor athletics will be located in the golf cart with a certified athletic trainer.

References

1. Anderson, S.A, Casa, D.J., Courson, R.W., Guskiewicz, K.M., Heck, J.F., Jimenez, C.C., McDermott, B.P., Miller, M.G., Stearns, R.L., Swartz, E.E., & Walsh, K.M. (2012). *National Athletic Trainers' Association Position Statement: Preventing Sudden Death in Sports*. J Athl Train, 47(1), 96-118.

2. Anderson, J., Courson, R.W., Kleiner, D.M., & McLoda, T.A. (2002). *National Athletic Trainers' Association Position Statement: Emergency Planning in Athletics*. J Athl Train, 37(1), 99-104.

3. Casa, D.J. (2012). *Preventing sudden death in sport and physical activity*. Sudbury, MA: Jones & Bartlett Learning.

4. University of Georgia Sports Medicine (2007*). Asthma medication metered dose inhaler (mdi) policies and procedures*. University of Georgia Emergency Action Plan.

Sudden Cardiac Arrest Policies and Procedure

Introduction

Sudden Cardiac Arrest (SCA) is the leading cause of death in young athletes. Athletes are considered the healthiest members of our society, and their unexpected death during training or competition is a catastrophic event with widespread implications. The incidence of sudden cardiac death in high school athletes is estimated to be 1:100000 to 1:200000. Cardiopulmonary resuscitation (CPR) is critical to maintaining the supply of oxygen to vital organs, but the single most effective treatment for SCA is defibrillation. Access to early defibrillation and an automated external defibrillator (AED) should be part of standard emergency planning for coverage of athletic activities.

The American Heart Association (AHA) uses four links in a chain (the "Chain of Survival") to illustrate the important time-sensitive actions for victims of SCA.

- Early recognition of the emergency and activation of the EMS or local emergency response system: "phone 911"
- Early bystander CPR: immediate CPR can double or triple the victim's chance of survival from ventricular fibrillation (VF) SCA
- Early delivery of a shock with a defibrillator: CPR plus defibrillation within 3 to 5 minutes of collapse can produce survival rates as high as 49% to 75%
- Early advanced life support followed by post-resuscitation care delivered by health care providers

Recognition of SCA

Recognition of SCA in athletes may be difficult due to the relatively low overall occurrence. SCA should be suspected when an athlete presents as collapsed and unresponsive; gasping, gurgling, snorting, moaning, or labored breathing noises; seizure-like activity; a blow to the chest. Myoclonic jerking or seizure-like activity is often present after collapse from SCA and should not be mistaken for a seizure. Occasional or agonal gasping should not be mistaken for normal breathing.

Management of SCA

CPR: Victims of SCA need immediate CPR. CPR provides a small but critical amount of blood flow to the heart and brain. CPR prolongs the time VF is present and increases the likelihood that a shock will resolve the VF and allow the heart to resume an effective rhythm and effective systemic perfusion. CPR is especially important if a shock is not delivered for 4 or more minutes after collapse. Defibrillation does not "restart" the heart; defibrillation "stuns" the heart, briefly stopping VF and other cardiac electrical activity. If the heart is still viable, its normal pacemakers may then resume firing and produce and effective ECG rhythm that may ultimately produce adequate blood flow.

"Effective" chest compressions are essential for providing blood flow during CPR. To give "effective" chest compressions, "push hard and fast." Compress the adult chest at a rate of 100 compressions per minute, with a compression depth of 1.5-2 inches (approx.. 4-5 cm). Allow the chest to recoil completely after each compression, and allow approximately equal compression and relaxation times. Minimize interruptions in chest compressions. Rescuer fatigue may lead to inadequate compression rates or depth. Significant fatigue and shallow compressions are seen after one minute of CPR, although rescuers may deny that fatigue is present for ≥5 minutes. When two or more rescuers are available, it is reasonable to switch the compressor every two minutes (or after five cycles of compressions and ventilations at a ratio of 30:2). Every effort should be made to accomplish this switch in <5 seconds. If two rescuers are positioned on either side of the patient, one rescuer will be ready and waiting to relieve the "working compressor" every two minutes.

AED: An AED should be applied as soon as possible and turned on for rhythm analysis in any collapsed and unresponsive athlete. CPR should be implemented while waiting for an AED if not immediately available. Interruptions in chest compressions should be minimized and CPR stopped only for rhythm analysis and shock. CPR should be reinitiated immediately after the first shock with repeat rhythm analysis following two minutes or five cycles of CPR.

Healthcare providers must practice efficient coordination between CPR and defibrillation. When VF is present for more than a few minutes, the myocardium is depleted of oxygen and metabolic substrates. A brief period of chest compressions can deliver oxygen and energy substrates, increasing the likelihood that a abnormal rhythm will return after defibrillation (elimination of VF). Analysis of VF waveform characteristics predictive of shock success have documented that the shorter the time between chest compressions and delivery of shock, the more likely the shock will be successful. Reduction in the interval from compression to shock delivery be even a few seconds can increase the probability of shock success.

The rescuer providing chest compressions should minimize interruptions in chest compressions for rhythm analysis and shock delivery and should be prepared to resume CPR, beginning with chest compressions, as soon as a shock is delivered. When two rescuers are present, the rescuer operating the AED should be prepared to deliver a shock as soon as the compressor removes his or her hands from the victim's chest and all rescuers are "clear" of contact with the victim. The lone rescuer should practice coordination of CPR with efficient AED operation.

Shock First vs. CPR First: When any rescuer witnesses SCA and an AED is immediately available on-site, the rescuer should use the AED as soon as possible. When the SCA is not witnessed and/or the time interval from collapse to first shock is greater than five minutes, two minutes of CPR should be performed prior to defibrillation.

Provisions to Coordinate Care with Local EMS

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

Operator Consideration

Elk Grove High School utilizes the Medtronic Lifepak CR Plus defibrillator. These AEDs are designed for minimally trained rescuers. The AED gives verbal commands, step-by-step, for the rescuer to follow. These AEDs are built with the same advanced defibrillation technology used by emergency medical services and hospital personnel.

Procedures for Training and Testing in the Use of AED

All personnel using the AED must complete and maintain American Heart Association training in CPR and AED use.

Location of and Maintenance Required for AEDs

The Elk Grove High School Sports Medicine program has access to seven AEDs. Three of these AEDs are portable. The mounted AEDs can be found at:

1. Athletic training room (under the television)
2. Main foyer of school (outside of cafeteria entrance)
3. Stadium (on wall outside concession stand)
4. Varsity baseball field (inside 1st baseline dugout)

The three portable AEDs and the AED located in the athletic training room will be inspected by the Head Athletic Trainer monthly and documented on the monthly AED inspection form. The Elk Grove High School custodial staff is responsible for inspecting the AEDs located in the main foyer, stadium, and varsity baseball field. If maintenance is needed the Head Athletic Trainer will notify Katie O'Keefe (kokeefe@d211.org) and she will handle the maintenance.

References

1. Anderson, S.A, Casa, D.J., Courson, R.W., Guskiewicz, K.M., Heck, J.F., Jimenez, C.C., McDermott, B.P., Miller, M.G.,
Stearns, R.L., Swartz, E.E., & Walsh, K.M. (2012). *National Athletic Trainers' Association Position Statement: Preventing*
Sudden Death in Sports. J Athl Train, 47(1), 96-118.
2. Anderson, J., Courson, R.W., Kleiner, D.M., & McLoda, T.A. (2002). *National Athletic Trainers' Association Position*
Statement: Emergency Planning in Athletics. J Athl Train, 37(1), 99-104.
3. Casa, D.J. (2012). *Preventing sudden death in sport and physical activity*. Sudbury, MA: Jones & Bartlett Learning.
4. University of Georgia Sports Medicine (2007). *Automated external defibrillator policies and procedure*. University of
Georgia Emergency Action Plan.

Diabetes Policies and Procedure

Introduction

Diabetes mellitus is a disorder of carbohydrate metabolism that is caused by inadequate production or utilization of insulin and inefficient use of blood sugar. Diabetes mellitus is classified into two types. Type 1 is also known as insulin dependent diabetes in which the pancreas either produces little or no insulin. In type 2 diabetes (non-insulin dependent diabetes) the pancreas either produces an insufficient amount of insulin or the cells do not effectively respond to the insulin. Diabetic emergencies include hypoglycemia and hyperglycemia. Normal fasting blood glucose levels are 60-100 mg/dL. Hypoglycemia occurs when blood glucose levels fall below 70 mg/dL. Hyperglycemia occurs when blood glucose levels exceed 180 mg/dL. According to the statistics from the Centers for Disease Control and Prevention, it is estimated that 23.6 million people are affected by diabetes. Among this group, approximately 185,000 are younger than 20 years, and 7.8 million are aged 20-39 years. This age group constitutes the majority of athletes which is of concern in the athletic environment.

Recognition of a Diabetic Emergency

Hypoglycemia

- Sudden onset
- Pale, cool, clammy skin
- Mood changes, disorientation, confusion, stupor
- Unresponsiveness (late stages)

Hyperglycemia

- Gradual onset
- Flushed, warm, dry skin
- Frequent urination
- Irregular breathing
- Fruity or sweet odor on breath
- Nausea, feeling and looking ill
- Drowsiness, disorientation
- Unresponsiveness (late stages)

Management of a Diabetic Emergency

1. Check for life-threatening conditions (ABCs)
2. If athlete's medical history is unknown, look for a medic alert tag, or ask bystanders whether they know if the athlete has diabetes.
3. If it is unclear whether the diabetic emergency is due to hypoglycemia or hyperglycemia, give a form of sugar. If sugar levels are low, recovery will be rapid. If sugar levels are high, additional sugar will not harm the athlete.
4. In the event of mild hypoglycemia (the athlete is conscious and able to swallow and follow directions), the athletic trainer may administer approximately 10-5 grams of carbohydrates (examples include 4-8 glucose tablets or two tablespoons of honey) and reassessing blood glucose levels immediately and 15 minutes later. Glucose may be given every 15 minutes if the athlete demonstrates improvement but has not returned to normal. If no improvement is noted, the athlete should be referred to the nearest emergency department.

   NOTE: Do not give food or drink if athlete is experiencing an altered state of consciousness.
5. In the case of sever hypoglycemia in a known diabetic, when that athlete is unconscious the use of Glucagon is permitted with 1 MG IN.

References

1. Anderson, S.A, Casa, D.J., Courson, R.W., Guskiewicz, K.M., Heck, J.F., Jimenez, C.C., McDermott, B.P., Miller, M.G., Stearns, R.L., Swartz, E.E., & Walsh, K.M. (2012). *National Athletic Trainers' Association Position Statement: Preventing Sudden Death in Sports.* J Athl Train, 47(1), 96-118.

2. Anderson, J., Courson, R.W., Kleiner, D.M., & McLoda, T.A. (2002). *National Athletic Trainers' Association Position Statement: Emergency Planning in Athletics.* J Athl Train, 37(1), 99-104.

3. Casa, D.J. (2012). *Preventing sudden death in sport and physical activity.* Sudbury, MA: Jones & Bartlett Learning

Concussion Policies and Procedure

Introduction

Concussion is a "complex pathophysiological process affecting the brain, induced by traumatic biomechanical forces. "Concussion may be caused either by direct blow to the head or by impulsive forces transmitted to the head by direct impact to another area of the body. Concussion typically results in the rapid onset of short-lived impairment of neurologic function that resolves spontaneously. It may result in neuropathologic changes, but the acute clinical symptoms largely reflect a functional disturbance rather than a structural injury. Concussion results in a graded set of clinical symptoms that may or may not involve a loss of consciousness. Resolution of the clinical and cognitive symptoms typically follows a sequential course, but it is important to note that in a small percentage of cases postconcussive symptoms may be prolonged. No abnormality is seen on standard structural neuroimaging studies in concussion.

Onfield or Sideline Evaluation

The athlete will be evaluated onsite following the emergency action plan as stipulated by the National Athletic Trainers' Association. If an athletic trainer is not available, the athlete will not return to practice or play. The coach will decide if 9-1-1 should be called. The parent/guardian should be called and informed of their child's condition. If 9-1-1 is called, an athletic administrator should be contacted immediately. The player is not to be left alone following the injury. Monitoring of the athlete for deterioration is essential over the initial few hours following the injury. The Palatine High School athletic trainers' sideline evaluation will consist of the SCAT evaluation. If a more serious injury is suspected (cerebral hematoma, Second Impact Syndrome) the athlete will be referred to the nearest emergency department by EMS. If a concussion is suspected, the athlete will be removed from participation. The athletic trainer will notify the athlete's parent/guardian and provide take home instructions.

Management

Prior to returning to any physical activity, including physical education class, the athlete must report to the athletic training staff for further evaluation. The athlete should not participate in any physical activity until cleared by the sports medicine staff. The athlete should receive as much cognitive rest as possible while symptomatic. Limiting television, video games, text messaging and other cognitive activities is highly recommended. The athletic training staff will administer a post injury ImPACT test 24-72 hours after the injury. These scores will be compared to the athlete's baseline scores or normative data if a baseline is not available. If the athlete still reports having symptoms, at least 48 hours must have elapsed since the first post-injury ImPACT test in order to take another post-injury test. The ImPACT test will be given every two days, until the athlete reports he/she is symptom-free, at which time they will be given the ImPACT test. This report, in conjunction with the athlete's medical care team assessment (which may include appropriate athlete-specific or normative ImPACT scores) will determine that the athlete may begin the gradual return-to-play program.

Return to Play Protocol

*Each step should take 24 hours

*An athlete may not move on to the next step of the sequence if symptoms return.

- Step 1: Light aerobic exercise to increase heart rate and blood pressure in the brain.
- Step 2: Perform moderate to heavy cardio and/or sports-specific drills
- Step 3: Light contact with no head impact activities
- Step 4: Full participation in practice with full contact
- Step 5: If no symptoms return in Step 4 and the ImPACT scores have returned to normal, then the athlete will be cleared to resume play with no restrictions.

If the athlete has symptoms during any of the above steps, then the process returns to the previous step with a minimum of 48 hours of rest before resuming the sequence.

References

1. Anderson, J., Courson, R.W., Kleiner, D.M., & McLoda, T. (2002). *National Athletic Trainers' Association Position Statement: Emergency Planning in Athletics.* J Athl Train, 37(1), 99-104.

2. Aubry, M., Cantu, R., Dvorak, J., Johnston, K., NcCrory, P., Meeuwisse, W. & Molloy, M. (2009). *Consensus Statement on Concussion in Sport: the 3rd International Conference on Concussion in Sport held in Zurich, November 2008.* Br JSports Med, 43(Supp I), 76-84.

Exertional Heat Illness Policies and Procedure

Introduction

Exertional heat stroke (EHS) occurs when core body temperature is elevated to a dangerous level (usually 105˚F or greater) with concomitant signs of organ system failure due to hyperthermia. This occurs when the thermoregulatory system is overwhelmed due to excessive heat production or inhibited heat loss and can progress to thermoregulatory system failure. The first marker of exertional heat stroke is often central nervous system dysfunction or changes. If this condition is not treated immediately and effectively it can lead to death.

EHS is the second leading cause of sudden death in athletes and can rise to the number one cause of sudden death in athletes during the summer months. The incidence of fatal EHS in American football players was about 1 in 350,000 participants from 1995-2002.

Recognition of Heat Stroke

The ability to rapidly and accurately assess core body temperature and central nervous system (CNS) functioning is critical to the proper evaluation of EHS. The athletic training staff will not utilize rectal temperature without the proper equipment and authorization by the Elk Grove High School athletic administration and the team physicians. CNS dysfunction recognition is critical in recognizing EHS (altered consciousness, coma, convulsions, disorientation, irrational behavior, decreased mental acuity, irritability, emotional instability, confusion, hysteria, and/or apathy). Other possible findings may include nausea, vomiting, diarrhea, headache, dizziness, weakness, hot and wet or dry skin (important to note that skin may be wet or dry at time of incident), increased heart rate, decreased blood pressure, increased respiratory rate, dehydration, and combativeness.

Emergency Management of Heat Stroke

1. Immediately remove protective equipment, uniform, and any other clothing with the exception of undergarments.
2. Immerse the athlete up to the shoulders in ice water. The athlete's symptoms may worsen within the first ten minutesof immersion was immediately initiated. Water temperature should be close to 35.6 ˚F. Cool the athlete for 15-20 minutes or until athlete begins to shiver.
3. If ice-water immersion is not available, the athlete should be doused with cold water, fanned, and have ice placed over or massaged over his or her body. Cold, wet ice towels may be used if ice immersion is not available.
4. Remove athlete from immersion tub when temperature reaches 39 ˚C (15-20 minutes, but may take 30 minutes).
5. The athlete should not be immediately transported to the hospital if on-site medical care and appropriate cooling is available. Transport to emergency department should follow cooling.

Recognition of Heat Exhaustion

The most critical criteria for determination are obvious difficulty continuing intense exercise in heat, lack of severe hyperthermia (below 104 ˚F), and lack of severe CNS dysfunction. Other findings may include physical fatigue, dizziness, dehydration and/or electrolyte depletion, ataxia and coordination problems, syncope, profuse sweating, pallor, headache, nausea, vomiting, diarrhea, stomach/intestinal cramps, persistent muscle cramps, and rapid recovery with treatment.

Emergency Treatment of Heat Exhaustion

1. Remove athlete from play and immediately move to an air-conditioned or shaded area.
2. Remove excess clothing and equipment.
3. Cool athlete.
4. Have athlete lie comfortably with legs elevated above heart level.
5. If athlete is not nauseated, vomiting or experiencing any CNS dysfunction, rehydrate orally with chilled electrolyte drink or water.
6. Monitor heart rate, blood pressure, respiratory, and CNS status.
7. Transport to nearest emergency medical facility if rapid improvement is not noted with the above treatment.

References

1. Anderson, J., Courson, R.W., Kleiner, D.M., & McLoda, T.A. (2002). *National Athletic Trainers' Association Position Statement: Emergency Planning in Athletics*. J Athl Train, 37(1), 99-104.

2. Casa, D.J. (2012). *Preventing sudden death in sport and physical activity*. Sudbury, MA: Jones & Bartlett Learning.
3. University of Georgia Sports Medicine (2007). *Exertional heat illness protocol*. University of Georgia Emergency Action Plan.

Orthopedic Emergency Policies and Procedure

Initial Evaluation

The primary goals of the initial orthopedic evaluation are to determine whether or not a true orthopedic emergency is present, begin appropriate treatment, and determine the mode of transport for emergencies or routine extremity trauma. Evaluation of neurovascular status is the first step in the initial evaluation. Distal pulse, motor, sensation, and capillary refill (PMSC) should be assessed with any deficiencies and/or changes noted. Visual inspection for deformity and palpation for deformity and point tenderness should be performed followed by evaluation for gross joint instability. Clinical tests for suspected long bone fractures such as torque, compression and percussion may be utilized as appropriate by the athletic trainer. Applications of Initial Evaluation splints for fracture or gross joint instability is the final step prior to transport. If splints are applied to an extremity injury, PMSC should be evaluated both before and after placement of splints.

Orthopedic Emergencies

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

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

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

Delay of treatment of fractures and dislocations with neurovascular compromise may lead to disastrous consequences including loss of limb and even death. Immediate reduction or realignment by a physician should be performed. The athletic trainer should never attempt to reduce or realign a fracture or dislocation.

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

Splinting Guidelines

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

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

References

1. Anderson, J., Courson, R.W., Kleiner, D.M., & McLoda, T.A. (2002). *National Athletic Trainers’ Association Position Statement: Emergency Planning in Athletics*. J Athl Train, 37(1), 99-104.
2. University of Georgia Sports Medicine (2007). *Orthopedic injury protocol*. University of Georgia Emergency Action Plan.

Cervical Spine Injury Policies and Procedure

Introduction

A catastrophic cervical spine injury can be defined as "structural distortion of the cervical spinal column associated with actual or potential damage to the spinal cord." Serious spinal cord injuries can potentially cause devastating sequelae such as permanent neurologic impairment and premature mortality. The spinal injury that carries the greatest risk of immediate sudden death for the athlete occurs when the damage is both severe enough and at a high enough level in the spinal column (above C5) to affect the spinal cord's ability to transmit respiratory or circulatory control from the brain. The estimated incidence of cervical spine injuries with spinal cord damage in the United States is 11,000 cases each year. Athletics is the fourth most common cause of cervical spine injuries; it is the second most common in people younger than 30 years. Cervical spine injuries are likely to occur in high-contact sports such as football as well as in sports which falling from a high elevation is possible, such as gymnastics, swimming and diving, track and field, and cheerleading.

Recognition of Cervical Spine Injury

Catastrophic cervical spine injury should be suspected when an axial loading mechanism is witnessed. During the initial assessment, the presence of any of the following findings, alone or in combination, heightens the suspicion for a potentially catastrophic cervical spine injury and requires the initiation of the spine injury management protocol: unconsciousness or altered level of consciousness, bilateral neurologic findings or complaints in upper or lower extremities, significant midline spine pain with or without palpation, and obvious spinal column deformity.

Management of Cervical Spine Injury

When a potential spine injury is suspected, rescuers should ensure that the cervical spine is in neutral position and should immediately apply manual cervical spine stabilization. If the spine is not in neutral position, rescuers should realign the cervical spine to minimize secondary injury to the spinal cord and to allow for optimal airway management. However, the presence or development of any of the following, alone or in combination, represents a contraindication for moving the cervical spine to neutral position: the movement causes increased pain, neurologic symptoms, muscle spasm, or airway compromise; it is physically difficult to reposition the spine; resistance is encountered during the attempt to realignment; or the patient expresses apprehension. If applicable, the facemask should be removed within one minute once decision to immobilize and transport has been made, regardless of respiratory status. Removal of helmet and shoulder pads should be deferred until the athlete has been transported to an emergency medical facility. If needed, the jaw-thrust maneuver should be used to open the airway. The front of the shoulder pads can be opened to allow access for CPR and defibrillation.

The rescuer controlling c-spine stabilization will be in command of transfer to spine board. Control of c-spine will not be transferred between healthcare providers unless the current stabilizer is fatigued or unable to maintain alignment. Manual stabilization of the head should be converted to immobilization using a combination of external devices (cervical collars, foam blocks).

References

1. Anderson, J., Courson, R.W., Kleiner, D.M., & McLoda, T.A. (2002). *National Athletic Trainers' Association Position Statement: Emergency Planning in Athletics*. J Athl Train, 37(1), 99-104.
2. Anderson, S.A, Casa, D.J., Courson, R.W., Guskiewicz, K.M., Heck, J.F., Jimenez, C.C., McDermott, B.P., Miller, M.G., Stearns, R.L., Swartz, E.E., & Walsh, K.M. (2012). *National Athletic Trainers' Association Position Statement: Preventing Sudden Death in Sports*. J Athl Train, 47(1), 96-118.
3. Boden, B.P., Courson, R.W., Decoster, L.C., Horodyski, M., Norkus, S.A., Rehberg, R.S., Swartz, E.E., & Waninger, K.N. (2009). *National athletic trainers' association position statement: acute management of the cervical spineinjured athlete*. Journal of Athletic Training. 44(3); 306-331.
4. Casa, D.J. (2012). *Preventing sudden death in sport and physical activity*. Sudbury, MA: Jones & Bartlett Learning.
5. University of Georgia Sports Medicine (2007). *Suspected spinal cord injury protocol*. University of Georgia Emergency

Township High School District 211

Head Injury Care and Return to Play Guidelines

Head injuries are much different than injuries to other parts of the body, and therefore need to be treated in a different manner. Scientific studies show that brain injuries in children and adolescents take longer to heal than those same injuries do in adults.

The following are guidelines that are to be followed when an athlete incurs a head injury.

Signs/Symptoms of a Concussion (include but are not limited to):

Coach/Parent Observes These Signs	Athlete Reports These Symptoms
Confusion; forgetfulness (forgets plays)	Headache; sensitivity to light/noise
Moves clumsily; answers questions slowly	Feels sluggish, foggy and/or dizzy
Shows behavior/personality changes	Double or fuzzy vision; nausea
(irritability, depression)	Concentration or memory problems
Forgets events prior to and/or after a hit	Change in sleep patterns
Loss of consciousness, even temporarily	

If an athlete shows **any** of the above signs, the athlete should not return to play, and an additional evaluation should be performed.

On-field or Sideline Evaluation

- The athlete will be evaluated onsite following the emergency action plan as stipulated by the National Athletic Trainers' Association.
- If no athletic trainer is available, the athlete will not return to practice or play. The coach will decide if 911 should be called. The parent(s) should be called and informed of their child's condition. If 911 is called, an athletic director should be contacted immediately.
- The player is not to be left alone following the injury. Monitoring of the athlete for deterioration is essential over the initial few hours following the injury.
- The appropriate disposition of the athlete must be determined by the athletic trainer and/or the team physician (if available).

Township High School District 211
Head Injury Care and Return to Play Guidelines

A student/athlete who exhibits signs, symptoms, or behaviors consistent with a concussion in any activity, practice, or contest shall be removed from all participation and the parents/guardians will be notified.

Prior to returning to physical activity (including physical education class) student/athletes must report to the athletic trainer. The student/athlete should not participate in any physical activity until cleared by the athletic training staff. Student/athletes should receive as much cognitive rest as possible while symptomatic. Limiting television, video games, text-messaging and other cognitive activities is highly recommended.

District 211 certified athletic trainers will use the ImPACT neurocognitive screening tool as one way to evaluate a student/athlete's post-injury status. This test will be administered under the direction of a certified athletic trainer according to the prescribed protocol below:

Post-Injury Testing

ImPACT Post-Injury 1: The student/athlete will be given the ImPACT test following the injury, but no sooner than 24 hours after the injury. Test results will be compared to baseline scores. Additionally, the athletic trainer will notify the coach(s) and parents of the status of the student/athlete.

ImPACT Post-Injury 2: If further testing is needed, a second test will be administered once the student/athlete is symptom free. If a student/athlete fails Post-Injury test 1, and additional testing is needed, a minimum of 48 hours must lapse prior to re-testing. Athletic trainers have the discretion to prolong testing based on their evaluation. If symptoms persist and ImPact scores do not improve within 7-10 day of initial injury, the athletic trainer will consider referring the student/athlete to a physician or other appropriate health care professional for further evaluation.

Special Considerations

Repeat Concussions: Recovery times are typically longer for student/athletes suffering from repeated concussions within a short time frame. Testing for return to play will be at the discretion of the athletic trainer. If symptoms do not improve, the athletic trainer may consider referring the student/athletic to a physician or other appropriate health care professional for further evaluations.

Extenuating circumstances: Student/athletes known to have extenuating circumstances such as, IEP, 504 plans, or other psychosocial issues may experience a longer recovery window due to pre-existing conditions. These cases will be monitored on an individual basis by the athletic trainer, and other appropriate school personnel.

Return to Play

Return to play: After the student/athlete has been successful on the ImPact test, they may begin a graduated return-to-play protocol. Each of the steps listed below should occur 24 hours apart. An athlete may not progress to the next step if symptoms persist.

Step 1: Light aerobic exercise to increase heart rate and blood pressure in the brain
Step 2: Perform moderate to heavy cardio and/or sport specific drills
Step 3: Progression to more complex training drills, no head impact activities
Step 4: Full participation in practice, including contact and intensity level applicable to the sport. If a practice precedes a competition, and does not include contact the athletic trainer must simulate contact for evaluation purposes.
Step 5: Return to play with no restrictions

If the student/athlete has symptoms during any of the above steps, then the process returns to the previous step with a minimum of 48 hours of rest before resuming the sequence.

Post-concussion Consent Form (RTP/RTL)

Date _____

Student's Name _____ **Year in School** 9 10 11 12

By signing below, I acknowledge the following:

1. I have been informed concerning and consent to my student's participating in returning to play in accordance with the return-to-play and return-to-learn protocols established by Illinois State law;
2. I understand the risks associated with my student returning to play and returning to learn and will comply with any ongoing requirements in the return-to-play and return-to-learn protocols established by Illinois State law;
3. And I consent to the disclosure to appropriate persons, consistent with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), of the treating physician's or athletic trainer's written statement, and, if any, the return-to-play and return-to-learn recommendations of the treating physician or the athletic trainer, as the case may be.

Student's Signature _____

Parent/Guardian's Name _____

Parent/Guardian/s Signature _____

For School Use only

☐ Written statement is included with this consent from treating physician or athletic trainer working under the supervision of a physician that indicates, in the individual's professional judgement, it is safe for the student to return-to-play and return-to-learn.

Cleared for RTL

Date _____

Cleared for RTP

Date _____

MID SUBURBAN LEAGUE WEATHER GUIDELINES

Below you will find recommended guidelines and procedures for suspending, canceling, or conducting practices and competitions as it relates to extreme weather conditions. Following the recommended guidelines can reduce the risk and incidents associated with extreme weather conditions.

COMPETITION

Decisions to cancel Mid Suburban League **competitions** will be made by mutual agreement between the following designated administrators: District 220 Athletic Director, District 211 Director of Athletics, and designated District 214 Administrator.

PRACTICES

Decisions to cancel and/or suspend athletic practices will be determined on-site by an athletic administrator and/or certified athletic trainer. All MSL schools must adhere to the following guidelines for practices.

Heat Index 90 - 95 degrees

- Implement mandated water breaks
- Monitor and **decrease level of intensity** for drills/practice
- Emphasize instruction over conditioning

Heat Index 96 - 100 degrees

- Athletic Directors and designated district administrators (per above) will actively monitor temperatures until the heat index is below 95 degrees
- Practices will be limited to 90 minutes
- Implement mandated water breaks
- Monitor and **decrease level of intensity** for drills/practices
- Emphasize instruction over conditioning
- If the heat index reaches or exceeds 95 degrees at any time throughout a practice, the practice must cease 90 minutes from the original practice start time
- Walk-throughs are considered a part of the 90 minutes and may not be additional practice time
- Once a team leaves the field due to heat index, they may not return until the heat index is below 95 degrees
- A certified athletic trainer should be present (on-site) at practices

Heat Index exceeding 100 degrees

- All practices will be suspended
- Teams may resume practices once the heat index reading is below 100 degrees
- If practices have not yet begun, teams may practice once the heat index reading is below 100 degrees
- Decisions to suspend **competition(s)** will be made based on mutual consent by designated athletic administrators in cooperation with the respective district offices

MSL Football Acclimatization Guidelines

- Summer and fall practice sessions must adhere to current *IHSA bylaws* pertaining to weather and acclimatization.

Lightning and Thunder

- Lightning detection systems should be used to determine proximity and activity of lightning. If the lightning detection system sounds, teams should move indoors immediately
- Teams may return outdoors once the lightning detection system signals an "all-clear".
- If a lightning detection system is not available, or does not function properly, teams should move indoors once lightning is visible, or thunder is heard. Teams should remain indoors until no lightning/thunder is present for a minimum of 30 minutes

Extreme Cold

- All athletes should be properly clothed for outdoor practices
- Outdoor practices are not permitted when the wind chill is below 0 degrees
- Decisions to suspend **competition(s)** will be made based on mutual consent by designated athletic administrators in cooperation with the respective district offices

Food Allergy Action Plan

Emergency Care Plan

Place Student's Picture Here

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____

Weight: _____ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Extremely reactive to the following foods: _____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

TURN FORM OVER **Form provided courtesy of Food Allergy Research & Education (FARE) (www.foodallergy.org) 5/2013**