EMERGENCY ACTION PLAN FOR ATHLETICS

Prepared By:
Christian M. Stipe, ATC, LAT
Abigail Duhe, ATC, LAT

For:
St. Paul's School
917 S. Jahncke Ave.
Covington, LA 70434

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ST. PAUL'S SCHOOL
EMERGENCY ACTION PLAN FOR ATHLETICS

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

Introduction

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

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

Components of the Emergency Action Plan

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

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

Emergency Plan Personnel

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

Roles within the Emergency Team

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

The development of an emergency action plan cannot be complete without the formation of an emergency team. The emergency team may consist of a number of healthcare providers including physicians, emergency medical technicians, coaches, parents, and, possibly, other bystanders. Roles of these individuals within the emergency team may vary depending on various factors such as the number of members of the team, the athletic venue itself. There are four basic roles within the emergency team. The first and most important role is establishing safety of the scene and immediate care of the athlete. Acute care in an emergency situation should be provided by the most qualified individual on the scene. In most instances, this role will be assumed by the Certified Athletic Trainer, although if the team physician is present, he/she may be called in. The second role, EMS activation, may be necessary in situations where emergency transportation is not already present at the sporting event. This should be done as soon as the situation is deemed an emergency or a life-threatening event. Time is the most critical factor under emergency conditions. Activating the EMS system may be done by

anyone on the team. However, the person chosen for this duty should be someone who is calm under pressure and who communicates well over the telephone. This person should also be familiar with the location and address of the sporting event. Typically, the school administrator is the best choice to fulfill this role. The third role, equipment retrieval may be done by anyone on the emergency team who is familiar with the types and location of the specific equipment needed. Student athletic trainers and coaches are good choices for this role. The fourth role of the emergency team is that of directing EMS to the scene. One member of the team should be responsible for meeting emergency medical personnel as they arrive at the site of the emergency. Depending on ease of access, this person should have keys to any locked gates or doors that may slow the arrival of medical personnel. A student athletic trainer, administrator, or coach may be appropriate for this role.

Activating the EMS System

Making the Call:

911 (all life-threatening emergencies)

Providing Information:

- name, address, telephone number of callers
- nature of emergency, whether medical or non-medical *
- number of athletes
- condition of athlete(s)
- first aid treatment initiated by ATC/Physician
- specific directions as needed to locate the emergency scene (i.e. “Come to the faculty parking lot on Elm St.”)
- other information as requested by dispatcher

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

Emergency Communication

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

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

Emergency Equipment

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

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

Medical Emergency Transportation

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

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

An **emergency** is the need for Emergency Medical Services (EMS) to give further medical attention and/or transport an athlete to the hospital. It is important in these situations that coordination between the athletic trainer, coaches, administration and student responders be effective. This is intended to delineate roles and outline the protocol to be followed should an emergency occur. Situations when 911 should be called are:

- an athlete is not breathing
- an athlete has lost consciousness
- it is suspected than an athlete may have a neck or back injury
- an athlete has an open fracture (bone has punctured through the skin)
- severe heat exhaustion or suspected heat stroke

Non-Medical Emergencies

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

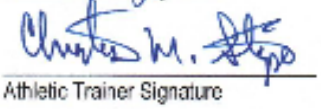
Conclusion

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

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

Policy Approvals

The signatures below indicate approval of these policies and protocols. The signature(s) and date(s) encompass the entire document. This policy is effective for one year following the date written below.

Joseph Gonzales MD Team Physician Name Printed	 Team Physician Signature	06-28-21 Date
Abigail J. Duke Athletic Trainer Name Printed	 Athletic Trainer Signature	6.28.21 Date
Christian M. Stipe Athletic Trainer Name Printed	 Athletic Trainer Signature	6/28/21 Date
Samuel T. Francis Athletic Director Name Printed	 Athletic Director Signature	6/28/2021 Date
Trevor Watkins Principal Name Printed	Trevor Watkins Principal Signature	6/28/2021 Date

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ST.PAUL'S SCHOOL
ATHLETIC POLICIES AND PROCEDURES

Over the Counter Medications

Usually, over the counter medications will not be dispensed by the Athletic Trainer. However, this may vary from student to student in special situations. This is a decision that will be made between the parent, St. Paul's School and its Athletic Trainer. Some special situations would include but not be limited to: Gatorlytes for hydration, Benadryl for suspected allergic reaction or Glutose for diabetes.

Physician Referrals

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

Getting Hurt on the Field

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

Other Injury Management

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

Athletic Participation Forms

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

Coaching First Aid & CPR Training

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

Travel Kits for Coaches

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

Injury Privacy and the Law

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

DEALING WITH SPORT EMERGENCIES AT ST. PAUL'S SCHOOL

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

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

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

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

Emergency Equipment: Supplies and equipment brought to the field for games or available in the athletic training room include taping/bandaging supplies, wound care supplies, splints/immobilizers, crutches, trauma kit, injury ice and general medical supplies. An AED is located at Heap Field, upstairs in the press box.

Roles of Certified Athletic Trainer (ATC)

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

Roles of Coaches

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

Roles of Administrative Staff

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

Emergency Chain of Command

1) Team Physician
2) Certified Athletic Trainer
3) Athletic Director
4) Administrator
5) Head Coach
6) Assistant Coach
7) Other Athletes

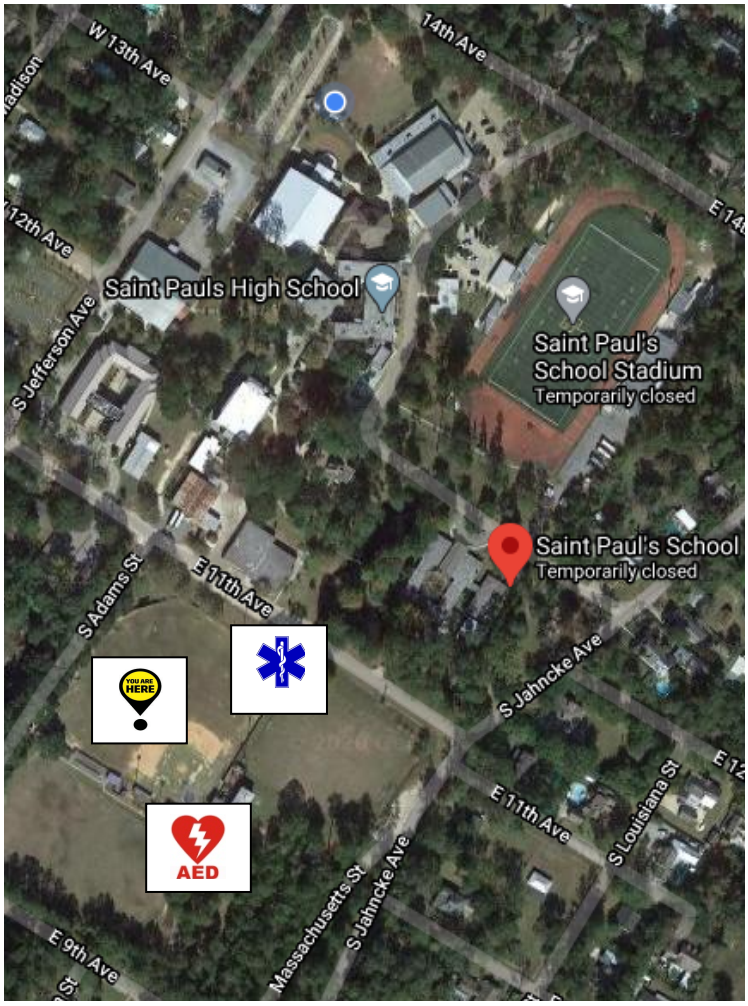
Roles of First Responder

1) Assess severity of injury and provide appropriate first aid as needed.
2) If life-threatening emergency present (unconscious, neck/spine injury, severe bleeding, not breathing, etc.), then call 9-1-1 immediately. Send for AED if necessary and have someone meet ambulance. (If Any Doubt Call Athletic Trainer)
3) If life-threatening emergency NOT present (sprain, bruise, etc.), then call one of the Athletic Trainers (AT) listed below immediately:
    a) Chris Stipe (985) 789-4105
    b) Abbie Duhe (205) 307-9990
4) If AT is not available, then call a parent and/or Athletic Director (AD) Sam Francs (504) 401-7032 immediately.
5) Calm the athlete and continue first aid as needed until help arrives.
6) Submit a Notification of Injury Form to the business office ASAP.

Venue Directions:

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

Venue Map: *Heap Field - Baseball*



= You Are Here

= Ambulance Entry Point

= AED Location

St. Paul's School Emergency Action Plan
New Gymnasium - Basketball, Wrestling and Football

Location: The new gymnasium is located on S. Jefferson Ave. between W. 13th Ave. and W. 12th Ave.

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

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

Emergency Equipment: Supplies and equipment brought to the field for games or available in the athletic training room include taping/bandaging supplies, wound care supplies, splints/immobilizers, crutches, trauma kit, injury ice and general medical supplies. An AED is located outside the coaches' office on the south side of the court.

Roles of Certified Athletic Trainer (ATC)

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

Roles of Coaches

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

Roles of Administrators/Coaches

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

Emergency Chain of Command

1) Team Physician
2) Certified Athletic Trainer
3) Athletic Director
4) Administrator
5) Head Coach
6) Assistant Coach
7) Other Athletes

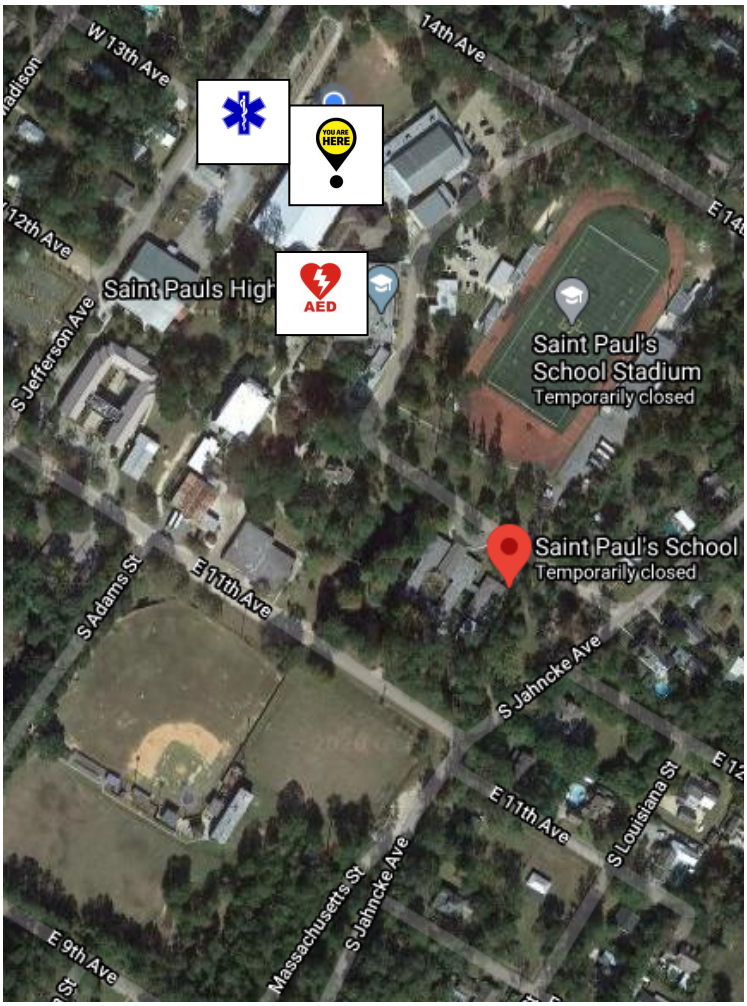
Roles of First Responder

1) Assess severity of injury and provide appropriate first aid as needed.
2) If life-threatening emergency present (unconscious, neck/spine injury, severe bleeding, not breathing, etc.), then call 9-1-1 immediately. Send for AED if necessary and have someone meet ambulance. (If Any Doubt Call Athletic Trainer)
3) If life-threatening emergency NOT present (sprain, bruise, etc.), then call one of the Athletic Trainers (AT) listed below immediately:
    a) Chris Stipe (985) 789-4105
    c) Abbie Duhe (205) 307-9990
4) If AT is not available, then call a parent and/or Athletic Director (AD) Sam Frances (504) 401-7032 immediately.
5) Calm the athlete and continue first aid as needed until help arrives.
6) Submit a Notification of Injury Form to the business office ASAP.

Venue Directions:

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

Venue Map: *New Gymnasium - Basketball, Wrestling and Football*



= You Are Here

= Ambulance Entry Point

= AED Location

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

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

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

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

Emergency Equipment: Supplies and equipment brought to the field for games or available in the athletic training room include taping/bandaging supplies, wound care supplies, splints/immobilizers, crutches, trauma kit, injury ice and general medical supplies. An AED is located inside visitor's ticket booth on the west side of the stadium.

Roles of Certified Athletic Trainer (ATC)

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

Roles of Coaches

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

Roles of Administrators/Coaches

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

Emergency Chain of Command

1) Team Physician
2) Certified Athletic Trainer
3) Athletic Director
4) Administrator
5) Head Coach
6) Assistant Coach
7) Other Athletes

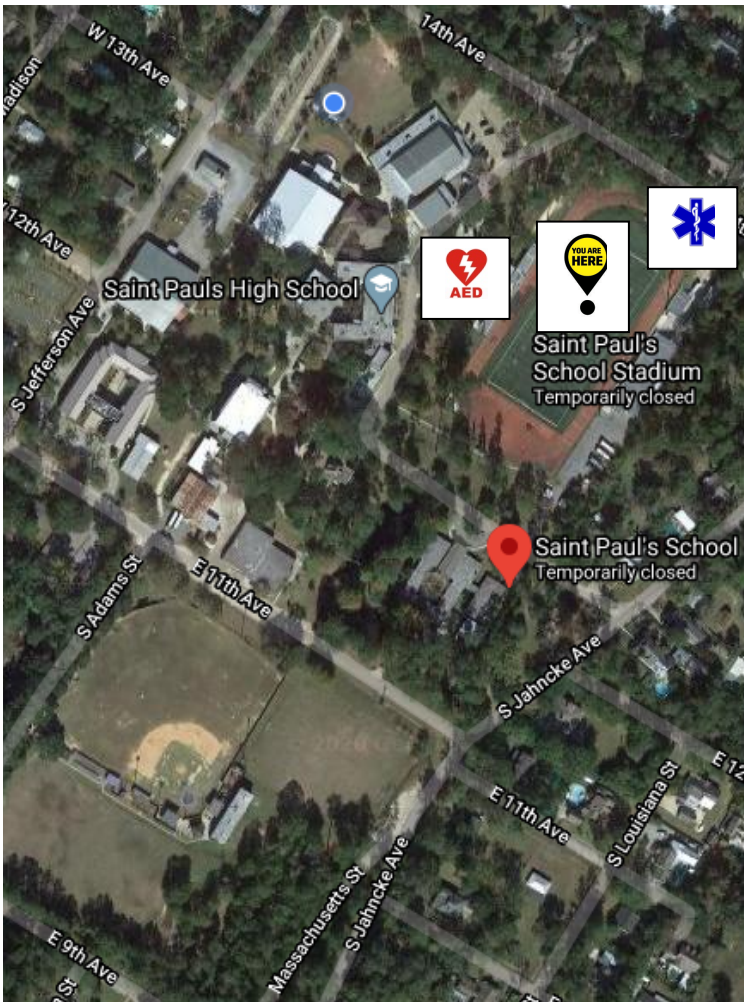
Roles of First Responder

1) Assess severity of injury and provide appropriate first aid as needed.
2) If life-threatening emergency present (unconscious, neck/spine injury, severe bleeding, not breathing, etc.), then call 9-1-1 immediately. Send for AED if necessary and have someone meet ambulance. (If Any Doubt Call Athletic Trainer)
3) If life-threatening emergency NOT present (sprain, bruise, etc.), then call one of the Athletic Trainers (AT) listed below immediately:
    a) Chris Stipe (985)789-4105
    d) Abbie Duhe (205)307-9990
4) If AT is not available, then call a parent and/or Athletic Director (AD) Sam Frances (504) 401-7032 immediately.
5) Calm the athlete and continue first aid as needed until help arrives.
6) Submit a Notification of Injury Form to the business office ASAP.

Venue Directions:

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

Venue Map: Hunter Stadium - Football, Soccer, Track, Cross Country, Lacrosse & Rugby



= You Are Here

= Ambulance Entry Point

= AED Location

St. Paul's School Emergency Action Plan
Old Gymnasium - Wrestling, Basketball & Powerlifting

Location: The old gymnasium is located at the intersection of De La Salle Dr. and E. 14th Ave.

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

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

Emergency Equipment: Supplies and equipment brought to the field for games or available in the athletic training room include taping/bandaging supplies, wound care supplies, splints/immobilizers, crutches, trauma kit, injury ice and general medical supplies. An AED is located in the old gym lobby near the concession stand.

Roles of Certified Athletic Trainer (ATC)

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

Roles of Coaches

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

Roles of Administrators/Coaches

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

Emergency Chain of Command

1) Team Physician
2) Certified Athletic Trainer
3) Athletic Director
4) Administrator
5) Head Coach
6) Assistant Coach
7) Other Athletes

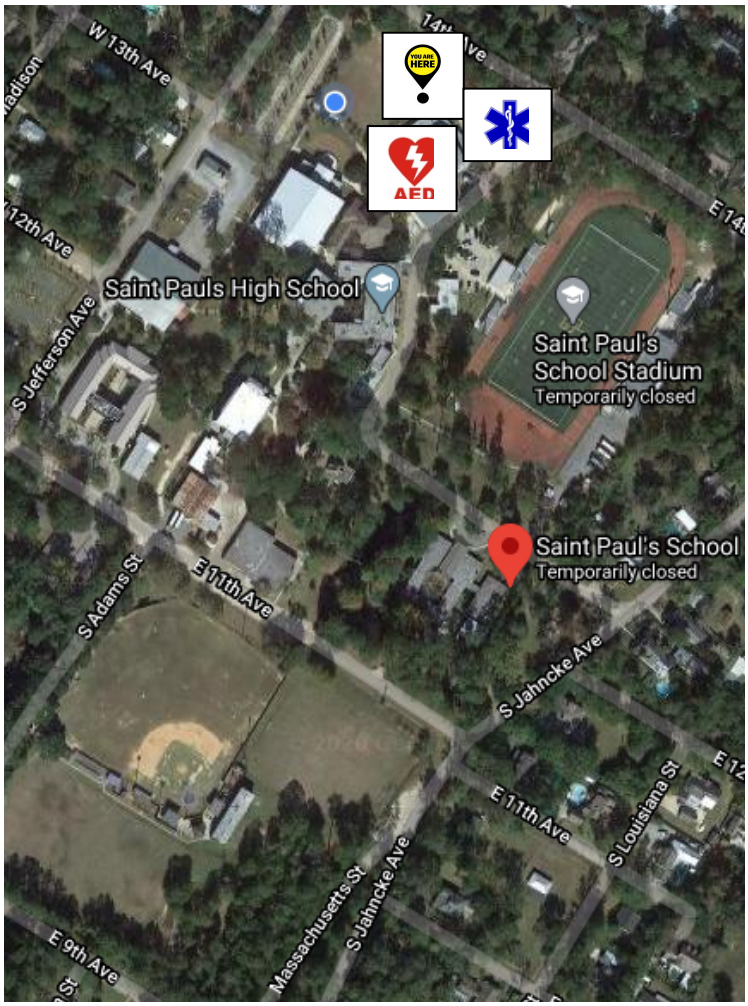
Roles of First Responder

1) Assess severity of injury and provide appropriate first aid as needed.
2) If life-threatening emergency present (unconscious, neck/spine injury, severe bleeding, not breathing, etc.), then call 9-1-1 immediately. Send for AED if necessary and have someone meet ambulance. (If Any Doubt Call Athletic Trainer)
3) If life-threatening emergency NOT present (sprain, bruise, etc.), then call one of the Athletic Trainers (AT) listed below immediately:
    a) Chris Stipe (985)789-4105
    e) Abbie Duhe (205)307-9990
4) If AT is not available, then call a parent and/or Athletic Director (AD) Sam Frances (504) 401-7032 immediately.
5) Calm the athlete and continue first aid as needed until help arrives.
6) Submit a Notification of Injury Form to the business office ASAP.

Venue Directions:

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

Venue Map: *Old Gymnasium - Wrestling, Basketball and Powerlifting*



= You Are Here

= Ambulance Entry Point

= AED Location

St. Paul's School Emergency Action Plan
Upper Varsity Field - Baseball, Soccer & Rugby

Location: The upper varsity field is located at the intersection of S. Adams St. and E. 19th Ave.

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

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

Emergency Equipment: Supplies and equipment brought to the field for games or available in the athletic training room include taping/bandaging supplies, wound care supplies, splints/immobilizers, crutches, trauma kit, injury ice and general medical supplies. An AED is located at Heap Field, upstairs in the press box.

Roles of Certified Athletic Trainer (ATC)

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

Roles of Coaches

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

Roles of Administrative Staff

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

Emergency Chain of Command

1) Team Physician
2) Certified Athletic Trainer
3) Athletic Director
4) Administrator
5) Head Coach
6) Assistant Coach
7) Other Athletes

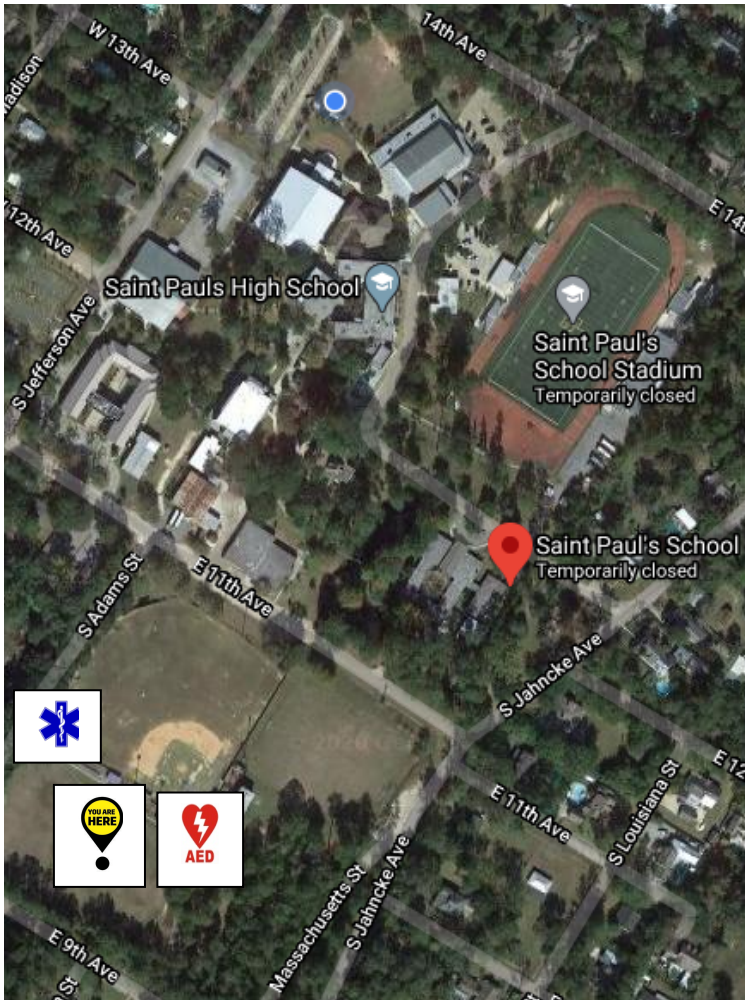
Roles of First Responder

1) Assess severity of injury and provide appropriate first aid as needed.
2) If life-threatening emergency present (unconscious, neck/spine injury, severe bleeding, not breathing, etc.), then call 9-1-1 immediately. Send for AED if necessary and have someone meet ambulance. (If Any Doubt Call Athletic Trainer)
3) If life-threatening emergency NOT present (sprain, bruise, etc.), then call one of the Athletic Trainers (AT) listed below immediately:
    a) Chris Stipe (985)789-4105
    f) Abbie Duhe (205)307-9990
4) If AT is not available, then call a parent and/or Athletic Director (AD) Sam Frances (504) 401-7032 immediately.
5) Calm the athlete and continue first aid as needed until help arrives.
6) Submit a Notification of Injury Form to the business office ASAP.

Venue Directions:

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

Venue Map: *Upper Varsity Field - Baseball, Soccer & Rugby*



= You Are Here

= Ambulance Entry Point

= AED Location

St. Paul's School Emergency Action Plan
Lower Practice Field - Soccer, Baseball & Football

Location: The lower practice field is located at the intersection of S. Jahncke Ave. and E. 11th Ave.

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

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

Emergency Equipment: Supplies and equipment brought to the field for games or available in the athletic training room include taping/bandaging supplies, wound care supplies, splints/immobilizers, crutches, trauma kit, injury ice and general medical supplies. An AED is located at Heap Field, upstairs in the press box.

Roles of Certified Athletic Trainer (ATC)

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

Roles of Coaches

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

Roles of Administrative Staff

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

Emergency Chain of Command

1) Team Physician
2) Certified Athletic Trainer
3) Athletic Director
4) Administrator
5) Head Coach
6) Assistant Coach
7) Other Athletes

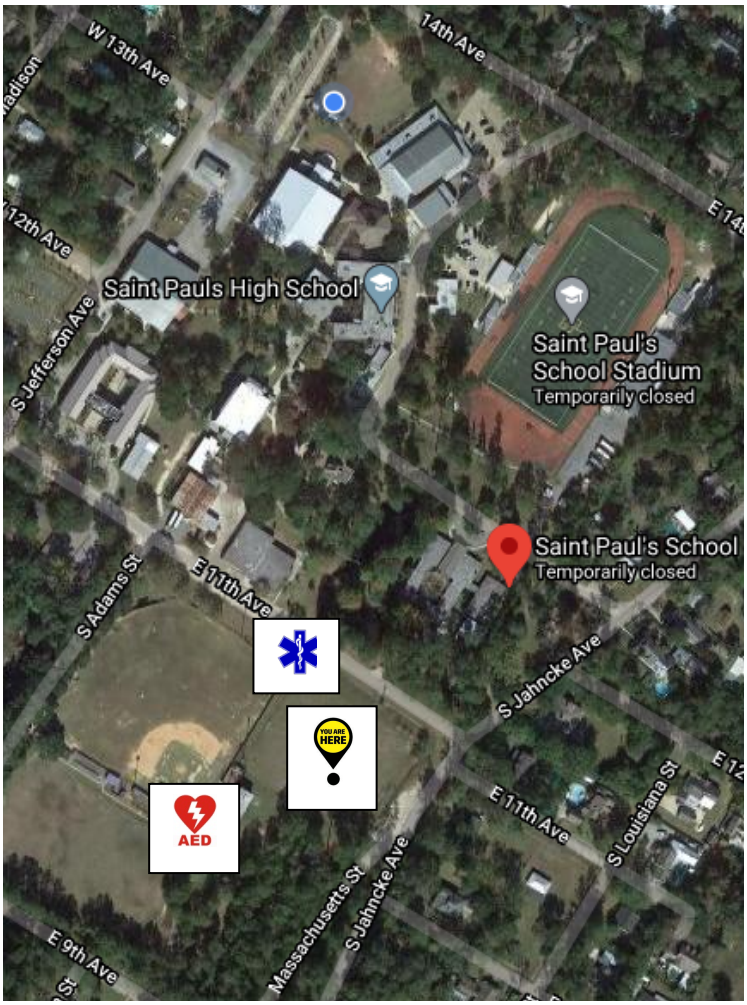
Roles of First Responder

1) Assess severity of injury and provide appropriate first aid as needed.
2) If life-threatening emergency present (unconscious, neck/spine injury, severe bleeding, not breathing, etc.), then call 9-1-1 immediately. Send for AED if necessary and have someone meet ambulance. (If Any Doubt Call Athletic Trainer)
3) If life-threatening emergency NOT present (sprain, bruise, etc.), then call one of the Athletic Trainers (AT) listed below immediately:
    a) Chris Stipe (985)789-4105
    b) Abbie Duhe (205)307-9990
4) If AT is not available, then call a parent and/or Athletic Director (AD) Sam Frances (504) 401-7032 immediately.
5) Calm the athlete and continue first aid as needed until help arrives.
6) Submit a Notification of Injury Form to the business office ASAP.

Venue Directions:

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

Venue Map: *Lower Practice Field - Soccer, Baseball & Football*



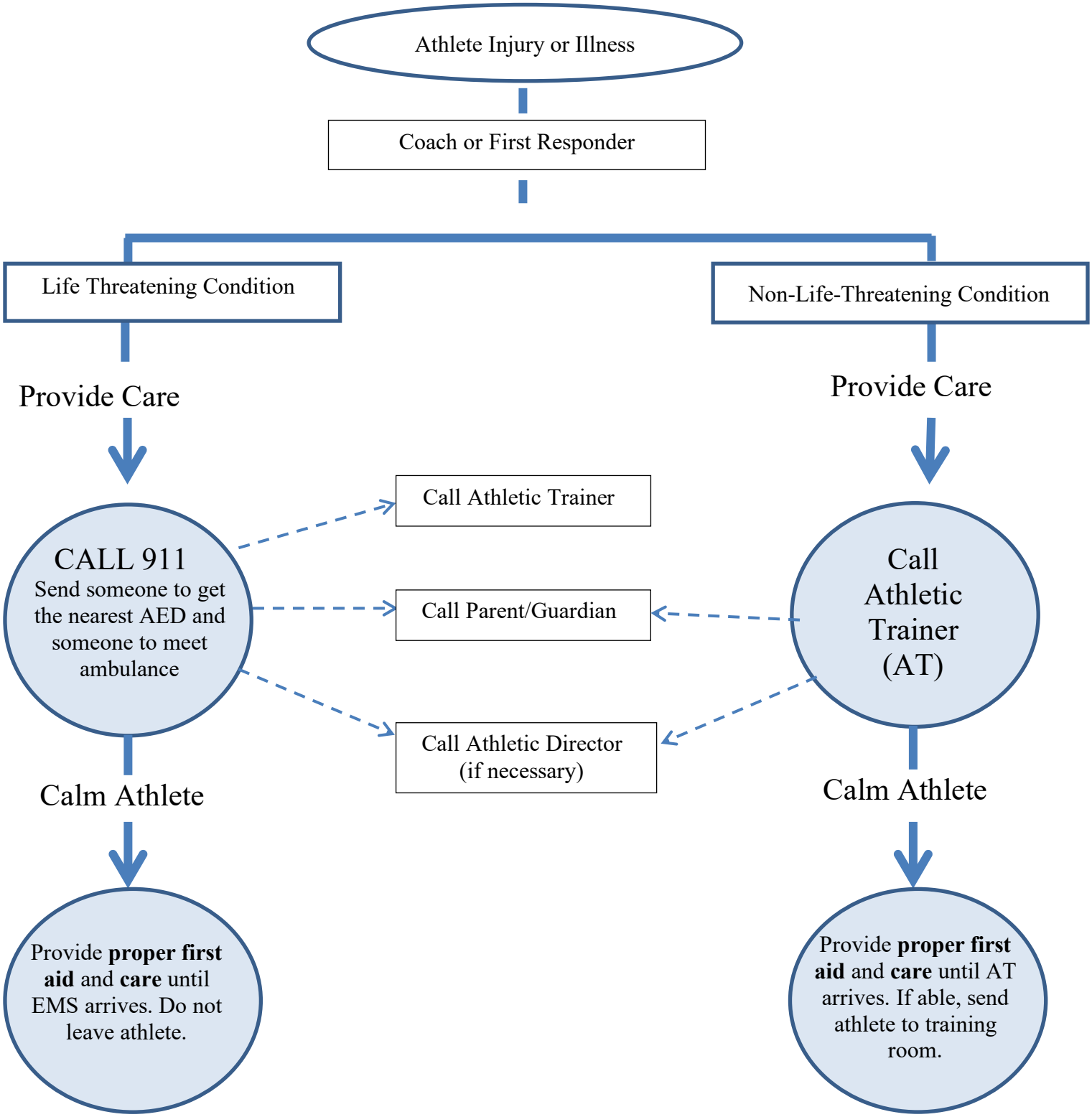
= You Are Here

= Ambulance Entry Point

= AED Location

EMERGENCY PROCEDURE FLOW CHART

ST. PAUL'S SCHOOL EAP FOR ATHLETICS WHEN ATHLETIC TRAINER NOT ON SITE



St. Paul's School
Emergency Contacts

Emergency Medical Services (EMS)	9-1-1
Covington Police Department – Dispatch	(985) 892-8500
Covington Fire Department – Dispatch	(985) 892-4242
St. Tammany Parish Hospital – Emergency Dept.	(985) 898-4000
Lakeview Regional Medical Center – Emergency Dept.	(985) 867-3800
Sam Frances, Athletic Director – Cellular Phone	(504) 401-7032
Trevor Watkins, Principal – Cellular Phone	(985) 249-1581
Chris Stipe, Athletic Trainer – Cellular Phone	(985) 789-4105
Abbie Duhe, Athletic Trainer – Cellular Phone	(205) 307-9990
St. Paul's School – Main Office	(985) 892-3200

Notification of Injury Form/Injury Report

Injured student's name (First and Last): _____

Description of student's injury: _____

Date student was injured: _____

Location at time of injury: _____

Activity participating in when injured: _____

Student's current grade: 8 9 10 11 12

Student's gender: M F

Signature of authorized school representative: _____

Title of authorized school representative: _____

Date this form was submitted to Athletic Trainer: _____

ST. PAUL'S SCHOOL EMERGENCY ACTION PLAN FOR ATHLETICS

PROTOCOLS, POLICIES & PROCEDURES

St. Paul's School
Heat Safety Protocol

Purpose of policy:
Exertional heat illness includes exercise-associated muscle cramps, heat syncope, heat exhaustion, and exertional heat stroke (EHS). Current best practice guidelines suggest that the risk of exertional heat injuries can be minimized with heat acclimatization and diligent attention to monitoring individuals participating in activities that place them at a higher risk for these types of injuries.[1] In the event an athlete sustains a heat illness, immediate and proper treatment is needed.

National governing bodies, such as the National Federations of High School Associations, National Collegiate Athletic Association (NCAA) and numerous state athletic/activity associations, have published guidelines for the prevention, monitoring and treatment of exertional heat illnesses. In addition, national authorities such as the National Athletic Trainers' Association and the Korey Stringer Institute have published research to support best practices in this area. The development of the organization's heat acclimatization guidelines will be based on the current best practice documents.

[1]Casa DJ, Demartini JK, Bergeron MF, et al. National Athletic Trainers' Association Position Statement: Exertional Heat Illnesses. *Journal of Athletic Training*. 2015; 50(9):986-1000.

Policy statement:
This policy describes the best practice procedures for the prevention, monitoring, and when necessary, the treatment of exertional heat illnesses for students/athletes, faculty and staff of St. Paul's School.

This policy will be a living, working document that is continually reviewed and updated yearly as the organization and our community changes.

Definitions:
- *Acclimatization* – The process of gradually increasing the intensity of activity in a progressive manner that improves the body's ability to adapt to and tolerate exercise in the heat.
- *Wet Bulb Globe Temperature* – The WBGT is a measurement tool that uses ambient temperature, relative humidity, wind, and solar radiation from the sun to get a comprehensive measure that can be used to monitor environmental conditions during exercise. WBGT is different than heat index, as it is a more comprehensive measurement of environmental heat stress on the body.
- *Non-Practice Activities* – Activities that include meetings, injury treatment, and film study.
- *Practice* – the period of time that a student-athlete engages in coach-supervised, school approved sport or conditioning related-activity. Practice time includes from the time the players report to the field until they leave.
- *Walk Through* – A period of time where players are reviewing positional strategy and rehearsing plays. Players do not experience contact and thus they do not wear equipment and the intensity of the activity is minimal often involving walking. This period of time shall last no more than one hour. It is not considered part of the practice time regulation. It may not involve conditioning or weight room activities. Players may not wear protective equipment during the walk through.
- *Recovery Time* – This period of time is defined as non-activity time outside of practices or games. NO ACTIVITY, including non-practice activity, can occur during this time. Proper recovery should occur in an air-conditioned facility, when possible and usually is a minimum of 3 hours in duration.

- *Rest Breaks* – This period of time occurs during practice and is a non-activity time that is in a 'cool zone' out of direct sunlight.
- *Exertional Heat Stroke* (EHS)– Defined as having a rectal temperature over 104°F-105°F (40.5°C), and central nervous system dysfunction (e.g. irrational behavior, confusion, irritability, emotional instability, altered consciousness, collapse, coma, dizzy, etc.).
- *Cooling Zone*- An area out of direct sunlight with adequate air flow to assist in cooling. A cold-water or ice tub and ice towels should be available to immerse or soak a patient with suspected heat illness. This may be outdoors or indoors depending on proximity to field.
- *Qualified Health Care Professional (QHP*) - As defined by the American Medical Association (AMA), "is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service."
- *Hypohydration*- (reduced hydration status) is a deficit of body water that is caused by acute or chronic dehydration.
- *Central Nervous System dysfunction*- includes any sign or symptom that the central nervous system is not working properly, including: dizziness, drowsiness, irrational behavior, confusion, irritability, emotional instability, hysteria, apathy, aggressiveness, delirium, disorientation, staggering, seizures, loss of consciousness, coma, etc.

Scope

This policy applies to all staff members (e.g., QHPs, athletic administrators, coaches, strength and conditioning staff, school administrators, advisors) of St. Paul's School who are associated with activities where heat illness poses a risk, including but not limited to, outdoor and indoor activities where high temperature and specifically high humidity environmental risks are present (e.g., athletics, intramurals, course instruction, marching band).

Procedures

Prevention

Pre-participation history and physical exam

1. A thorough medical history will be gathered (history of heat illness, sickle cell trait/disease, etc.).
2. Individuals with risk factors will be identified and counseled (see table below).

Risk Factors for Heat Illness	
Intrinsic	***Strategies to Minimize Risk***
High intensity exercise	Gradually phase in exercise and conditioning
Fever or illness	Monitor and remove at risk athletes as necessary
Dehydration	Educate coaches/athletes on proper hydration Provide adequate access to water
Overweight/obesity	Gradually phase in exercise and conditioning
Lack of heat acclimatization	Follow heat acclimatization program
Medications (antihistamines, diuretics, ADHD drugs)	Monitor and remove at risk athletes as necessary
Skin disorder (sunburn or malaria rubra)	Monitor athletes closely
Predisposing medical conditions	Monitor and remove at risk athletes as necessary
Extrinsic	***Strategies to Minimize Risk***
High ambient temperature, solar radiation or humidity	Avoid exercise in hotter parts of the day
Heavy gear or equipment	Gradually introduce equipment
Poor practice design	Educate coaches regarding strategies to minimize risk

3. When applicable the Athletic Trainer or persons responsible will be notified of individuals with pre-existing conditions that place the individual at risk of exertional heat illness.
4. As necessary, coaches are notified of individuals at higher risk.

Environmental Monitoring and Activity Modification/Cancellation

1. Environmental monitoring will occur utilizing a WBGT device.
2. Environmental monitoring will occur any time it is warm outside (i.e. over 70°F).
3. Environmental monitoring and activity modifications may be necessary for certain types of indoor facilities.
4. Monitoring of WBGT will occur every 30 minutes beginning at the scheduled practice time
    a. The Athletic Trainer will monitor the WBGT and notify the athletic director and coach via text message.
    b. The Athletic Trainer, in conjunction with the athletic director and coach, will make the decision for modification/cancelation of activity.
    c. WBGT will be measured on the field.
        i. All environmental monitoring will be recorded and shared with in-season head coaches and the athletic director every 30 minutes.
        ii. Any non-compliance by a head coach will be recorded and shared with the athletic director. The head coach will be advised that the athletic trainer will no longer be present and he (the head coach) now assumes responsibility.
5. Modifications will be made in accordance with the best practice guidelines for our region. We are in Category 3; therefore, we will follow the activity guidelines for that region.
    a. *Per Grundstein et al. Regional heat safety thresholds for athletes in the contiguous United States. Applied Geography, 2015 manuscript (https://ksi.uconn.edu/wpcontent/uploads/sites/1222/2018/08/RegionalWBGT_2015_AppliedGeography.pdf)*
6. Modifications are meant to be fluid, meaning if the environment gets more oppressive, the modifications get stricter. However, if environmental conditions improve, the modifications will be in line with the new environmental conditions.

Cat 3	Activity Guidelines
< 82.0	Normal Activities – Provide at least three separate rest breaks each hour with a minimum duration of 3 min each during the workout.
82.2 - 86.9	Use discretion for intense or prolonged exercise; Provide at least three separate rest breaks each hour with a minimum duration of 4 min each.
87.1 - 90.0	Maximum practice time is 2 h. For Football: players are restricted to helmet, shoulder pads, and shorts during practice. If the WBGT rises to this level during practice, players may continue to work out wearing football pants without changing to shorts. For All Sports: Provide at least four separate rest breaks each hour with a minimum duration of 4 min each.
90.1 - 91.9	Maximum practice time is 1 h. For Football: No protective equipment may be worn during practice, and there may be no conditioning activities. For All Sports: There must be 20 min of rest breaks distributed throughout the hour of practice.
≥ 92.1	No outdoor workouts. Delay practice until a cooler WBGT is reached.

Acclimatization

1. This acclimatization protocol applies to ALL sports.
2. Days one (1) through five (5) of the heat acclimatization periods consists of the first five (5) days of formal practice. During this time, athletes may not participate in more than one (1) practice per day.
    a. If a practice is interrupted by inclement weather or heat restrictions, the practice will recommence once conditions are deemed safe. Total practice time will not exceed three (3) hours in a single day.
    b. A one (1)-hour maximum walk-through is permitted during days one (1) – five (5) of the heat acclimatization period. However, a 3-hour recovery period will be inserted between the practice and walk-through (or vice versa).
3. During days one (1) – two (2) of the heat acclimatization period, in sports requiring helmets or shoulder pads, a helmet will be the only protective equipment permitted (goalies, as in the case of field hockey and related sports, will not wear full protective gear or perform activities that would require protective equipment).
4. During days three (3) – five (5), only helmets and shoulder pads will be worn. Beginning on day six (6), all protective equipment may be worn, and full contact may begin.
    a. Football only: On days three (3) – five (5), contact with blocking sleds and tackling dummies may be initiated.
    b. Full-contact sports: 100% live contact drills will begin no earlier than day six (6).
5. Beginning no earlier than day six (6) and continuing through day fourteen (14), double-practice days must be followed by a single-practice day. On single-practice days, one (1) walk-through is permitted, separated from the practice by at least three (3) hours of continuous rest. When a double-practice day is followed by a rest day, another double-practice day is permitted after the rest day.
6. On a double-practice day, neither practice will exceed three (3) hours in duration, and student-athletes will not participate in more than five (5) total hours of practice. Warm-up, stretching, cool-down, walk-through, conditioning, and weight room activities are included as part of the practice time.
    a. The two (2) practices will be separated by at least three (3) continuous hours of rest in a cool environment.
7. Because the risk of exertional heat illnesses during the preseason heat acclimatization period is high, we strongly recommend that an athletic trainer be on site before, during, and after all practices.

Hydration

1. Hypohydration represents a continuum from both a clinical perspective (mild = 1% to 5%, moderate= 5% to 10%, and severe= 10% body mass deficit) and an athletic perspective (mild= 1-3%, moderate=3-5% and severe=5% deficit).
2. Assessing Hydration Status: To ensure that athletes are hydrated prior to exercise a pre- and post-activity, measurement of bodyweight will be recorded whenever possible.
    a. Hydration before exercise will be maintained within + or - 1% of body mass compared to baseline values. A pre-activity hydration status of >3% body mass loss is associated with increased risk for heat illness therefore, if an individual is moderately dehydrated >3% body mass loss the individual will not be allowed to practice.
    b. Post exercise body mass should be <2% and athletes should not gain body mass >2%.
3. In addition to body mass loss, when feasible, first morning urine specific gravity (USG) increases the validity of hydration status assessment. Generally, a USG value >1.020 is considered hypohydrated. Also, personal cues of thirst sensation, urination frequency, and urine color are valuable indicators to consider.
4. Everyone will be aware of the main signs and symptoms of hypohydration listed below;
    a. Thirst

b. Dark colored urine (similar to apple juice)
c. Acute body weight loss >2%

5. Hypohydration is a predisposing factor for exertional sickling and those with sickle cell trait or disease will receive targeted education and hydration monitoring.
    a. Fluid Replacement: Water breaks will be provided based on the policy on environmental-condition guidelines using work to rest ratios. Water or other palatable fluids will be easily accessible before, during and after activity. Cool and flavored beverages are often preferred by athletes and will be made available when possible for optimal rehydration.
6. When possible, diet and rehydration beverages will include sufficient sodium (enough to replace losses) to prevent imbalances that may occur as a result of sweat and urine losses.
7. When needed, individualized hydration plans will be developed and sweat rate (see equation below);
    a. Environment, acclimatization state, body size, exercise duration, exercise intensity, and individual fluid preference and tolerance will be considered when calculating sweat rate.
    b. Sweat Rate Equation:
        - Sweat loss (L) = Body mass before exercise (kg) – Body mass after exercise (kg) + (Volume of fluid consumed during exercise [L]) – (Urine volume, if any [L])
        - Sweat rate (L/h) = Sweat loss (L) / Exercise duration (h)
8. When possible, fluid replacement will be optimized to prevent decreased performance. Core temp is 0.2°C to 0.25°C higher and heart rate is 3-5 bpm higher for every 1% increase in body mass loss.
9. If moderate (2%-5%) or severe (greater than 5%) hypohydration is identified, oral fluids will be administered.
10. If severe hypohydration is present with vomiting or diarrhea, EMS will be activated.

Monitoring

1. Monitoring of student-athletes safety will be continuous during any physical activity.
2. Athletic trainers, coaches, administrators and other athletics personnel will be educated on the signs and symptoms of exertional heat illness (see training/retraining in section 6).
    a. These signs and symptoms include (but are not limited to) the table below:

Rectal temperature greater than 104 (40°C) at time of incident.	Rapid pulse, low blood pressure, quick breathing
Headache	Dehydration, dry mouth, thirst
Confusion or just look “out of it”	Decreasing performance or weakness
Disorientation or dizziness	Profuse sweating
Altered consciousness, coma	Collapse, staggering or sluggish feeling
Nausea or vomiting	Muscle cramps, loss of muscle function/balance, inability to walk
Diarrhea	Irrational behavior, irritability, emotional instability

    b. Coaches and administrators will be educated annually.
        i. See training/retraining in section 6.

Treatment in the event of an exertional heat stroke (medical emergency)

Recognition

1. Any athlete with signs of central nervous system dysfunction during exercise in the heat should be suspected to be suffering from EHS until a rectal temperature confirms or refutes this diagnosis.
2. Patients with suspected EHS will have a temperature obtained via rectal thermometer by a QHP.

a. Rectal thermometers may include a traditional thermometer (e.g. small, discrete), electronic thermometers with a rigid end (e.g. hand-held digital thermometer) or a thermistor (e.g. long, flexible thermistor).
b. It is important to reiterate that during and following intense exercise in the heat, temporal, aural, oral, skin, axillary and tympanic temperature are <u>not</u> valid and should **never** be utilized in evaluating a potential exertional heat stroke.

3. *If a QHP is not available/present, cooling will begin immediately, and EMS will be called.*
4. Steps to obtain a rectal temperature:
    a. Remove the athlete from the playing field, to a shaded area.
    b. Drape the patient accordingly (with towels and sheets) for privacy.
        i. Note: It is encouraged that the medical professional asks a coach or other adult to witness the temperature measurement.
    c. Position the patient on their side with their top knee and hip flexed forward.
    d. Make sure the thermometer is cleaned with isopropyl alcohol.
    e. Make sure the probe is plugged into the thermometer (when applicable).
    f. Turn the thermometer on.
    g. Insert the probe 10-15cm past the anal sphincter.
    h. If you meet resistance while inserting, stop and remove the probe and then try again.
    i. Replace the patients clothing.
    j. Temperature duration:
        i. For use of a traditional thermometer or a hand-held digital thermometer, insert the probe for initial temperature. If temperature is at or above 104°F, initiate cooling protocol. See directions for continued monitoring in cooling protocol.
        ii. For use of a flexible thermistor, leave the probe in for the duration of the treatment.
    k. After the treatment has ended, remove the probe gently.

Cooling

1. If rectal temperature is between 102°-104°F, initiate cooling via rotating cold wet towels.
2. If rectal temperature is at or above 104°F, initiate the exertional heat stroke treatment protocol and contact EMS services immediately.
3. The patient must be moved to a cooling zone, begin appropriate treatment and continuously monitor the patient.
    a. For use of a traditional thermometer or a hand-held digital thermometer (any thermometer with a rigid end), obtain initial temperature, remove device, and calculate cooling rate (approximately 1°F every 3-5 minutes when using cold water immersion). When the QHP believes the temperature is within a safe range, remove patient from tub, and re-insert probe to confirm temperature. If temperature is not within the safe range, cooling will continue. Repeat procedure until temperature is confirmed to be within the safe range.
    b. For use of a flexible thermistor, keep the probe in for the duration of treatment.
4. Excess clothing shall be removed to aid cooling.
    a. If removal of clothing and/or equipment would cause delays of 5+ minutes, do not remove and initiate cooling.
5. Place patient in a cold-water (35-59°F) tub up to the neck.
    a. Wrap a towel across the chest and beneath both arms to prevent the athlete from sliding into the tub.
    b. Ice shall cover the surface of the water at all times.
    c. Water shall be continuously and vigorously stirred to maximize cooling.
    d. An ice-cold towel will be placed over the head/neck and rewet and replaced every 2 minutes.

e. Cooling shall cease when body temperature reaches 102°F.

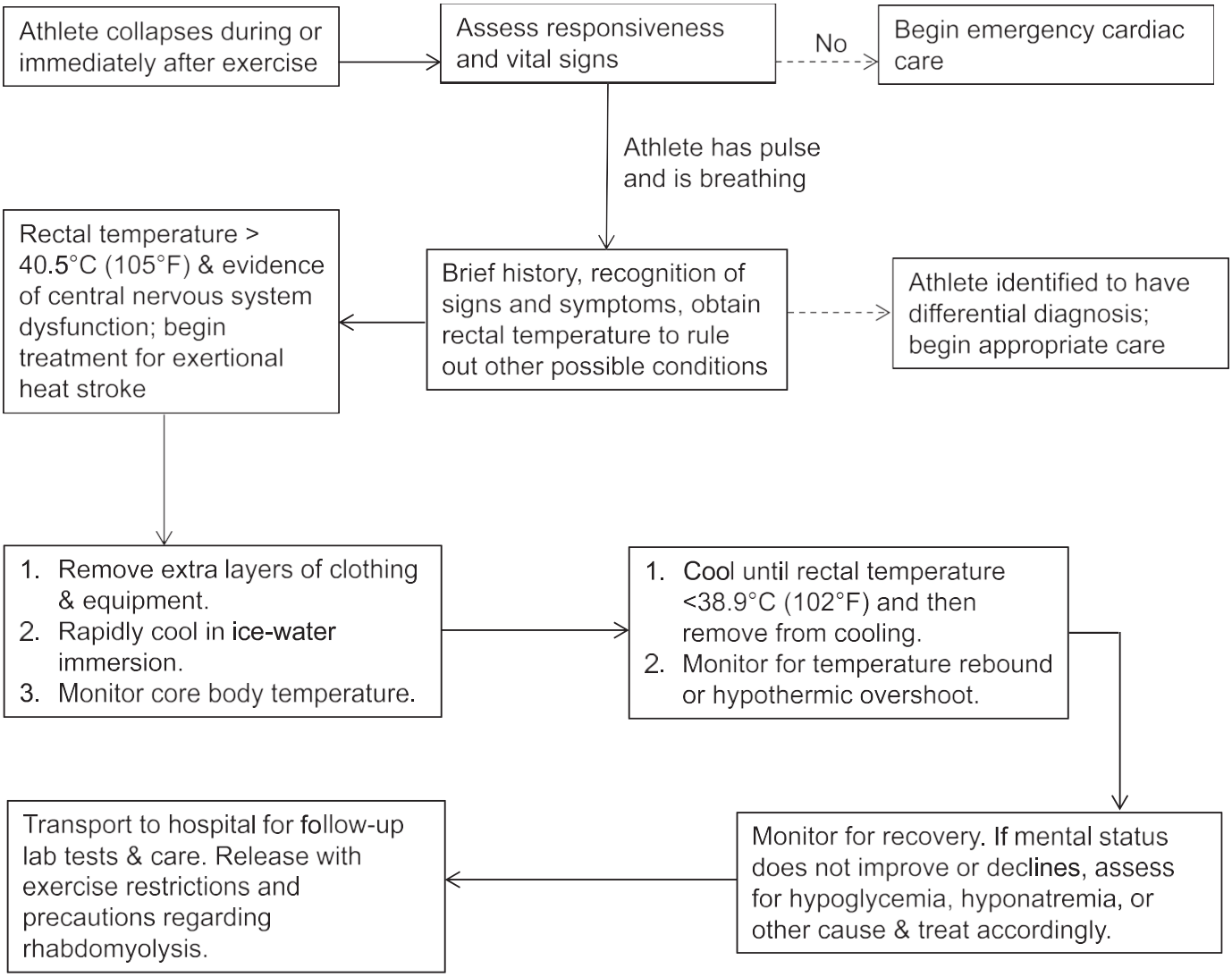
6. Cold Water Immersion (CWI) Tub
    a. Must be set up:
        i. CWI will be set up on all days where heat/humidity is high.
        ii. CWI will be set up on site of all practices during high heat/humidity times.
    b. Proper set-up includes:
        i. A tub filled with water.
        ii. Two chests filled with ice next to the tub ready for treatment.
        iii. Available bed sheet or large towels.
        iv. Towels for placement over the head and neck.
        v. Completion of set-up within 5-10 minutes prior to the practice/competition/event site.
7. Cool First, Transport Second
    a. When a patient is diagnosed with EHS, the principle of Cool First, Transport Second will be used.
        i. Note: EMS should not transport the patient until they reach 102°F due to the inability to continue vigorous cooling in the ambulance if QHP are on site. If QHP is not on site cool until medication transport arrives.

Vital sign monitoring

1. The QHP will monitor vital signs including core body (rectal) temperature, heart rate, blood pressure and other vital signs.
2. Vital signs will be monitored in times deemed to be a possible medical emergency every 15 minutes.

EMS

1. EMS must be called immediately if a patient is suspected of EHS.
2. HOWEVER, any patient with EHS must be **cooled FIRST and then transported via EMS.**
    a. This cool first transport second EAP protocol will be communicated/shared with EMS annually PRIOR to the first official sport practice at the school in accordance with the EAP policy and procedures.



Return to activity

Patients who have suffered an exertional heat illness must complete a rest period and obtain clearance from a physician before beginning a progression of physical activity under the supervision of a qualified medical professional. The following is the suggested protocol:

- Activity should first begin in a cool environment.
- Once patient has shown success with exercise in a cool environment, patient should then complete the heat acclimatization protocol (above) for progression back into exercise in a warm environment.
- Body temperature monitoring may be recommended during the first 1-2 weeks for those returning from EHS episode.

The following personnel have been trained to ensure a safe participation environment for all individuals, coaches, employees and staff mentioned in the Scope section of this document, who are engaged in activities that could put them at risk of exertional heat injuries.

Training/Retraining

This training includes, but is not limited to, the policy and protocols outlined in this document, the prevention of heat illnesses, identification of heat related illness', and when to initiate treatment for those believed to be suffering from an exertional heat illness.

URINE COLOR CHART

NO COLOR. TRANSPARENT
You're drinking a lot of water

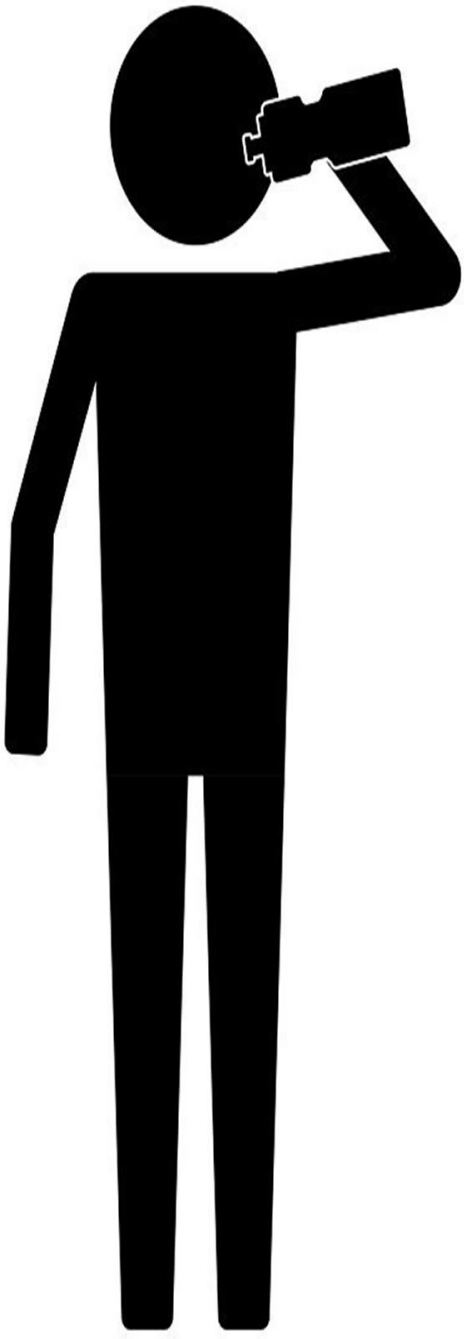
PALE STRAW COLOR
You're normal & well hydrated

TRANSPARENT YELLOW
Normal

DARK YELLOW
You need to drink some water soon

AMBER OR HONEY
Your body isn't getting enough water.

SYRUP OR BROWN ALE
You need to drink water. NOW & A LOT!



St. Paul's School

Blood Borne Pathogen Protocol

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

An exposure incident is defined as follows:

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

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

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

If an exposure occurs:

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

Universal Precautions

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

St. Paul's School

Helmet Removal Protocol

General Guidelines:

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

Face Mask Removal:

- The facemask should be removed with an appropriate face mask removal tool prior to transportation, regardless of current respiratory status.
- Those involved in the pre-hospital care of injured football players should have the tools (cordless screwdriver, trainer's angel, FM Extractor, etc.) for facemask removal readily available.

Football Helmet Removal:

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

- if the helmet and chin strap do not hold the head securely, such that immobilization of the helmet does not also immobilize the head.
- if the design of the helmet and chin strap is such that even after removal of the facemask the airway cannot be controlled, or ventilation be provided.
- if the facemask cannot be removed after a reasonable period of time.
- if the helmet prevents immobilization for transportation in an appropriate position.
- if athlete has a suspected spinal injury while participating in drill/training while wearing helmet only.

*If full pads are worn and helmet has to be removed, the shoulder pads must also be removed.

Helmet Removal:

Spinal immobilization must be maintained while removing the helmet.

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

Equipment:

Appropriate spinal alignment must be maintained.

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

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

St. Paul's School

Lighting Safety Protocol

1. Purpose of policy:

Lightning is the most dangerous and frequently encountered thunderstorm hazard that people experience every year. The purpose of this policy is to ensure proper education and prevention protocols are in place for the health and safety of our student athletes. Lightning injuries are one of the top ten causes of sport related death. As such, it is imperative to take the proper steps to prevent catastrophic injuries from this thunderstorm hazard. The "National Athletic Trainers Association Position Statement: Lightning Safety for Athletics" outlines the best practices for lightning safety. This includes "when thunder roars, go indoors" as well as the identification of safer structure and structures for evacuation in advance. By implementing proper policies, athlete safety. can be ensured when a storm with lightning approaches the playing fields.

[1]Walsh KM, Cooper MA, Holle R, Rakov VA, Roeder WP, Ryan M. National Athletic Trainers' Association Position Statement: Lightning Safety for Athletics and Recreation. *J Athl Train*. 2013; 48(2):258-270.

2. Policy statement:

This policy describes the best practice procedures for the prevention, monitoring, and when necessary, the treatment of lightning related injuries for students/athletes, faculty and staff of St. Paul's School.

This policy will be a living, working document that is continually reviewed and updated yearly as the organization and our community changes.

3. Definitions:

- *Safe Structure*— The safest structure is a fully enclosed, substantial building (one that has plumbing or electrical wiring) Fully-enclosed metal vehicles such as automobiles or school/team buses are also safe structures from the lightning threat.
- *Unsafe structures* – Generally, any structure in the open air is unsafe, such as dugouts, bleachers, golf carts, open garages, press boxes, etc. High places are also unsafe; avoid areas near trees, light poles, fences, and towers. Large bodies of water, including most swimming pools are not safe from the danger of lightning injury. Research has shown that using or being near plumbing (sinks, showers, and baths) or wiring (land-line phone, computer that is plugged in, appliances, etc.) can be unsafe from lightning danger.
- *Weather watcher* – An adult designated per venue, as the responsible person for monitoring the environment, initiating the 30-minute delay rule and for determining safe resumption of outdoor activities.
- *Lightning* – any lightning is dangerous. Intra-cloud (so-called 'heat lightning') lightning can with the next strike be cloud-to-ground lightning that can injure and kill. "Lightning" in this document refers to all lightning seen.

4. Scope:

This policy applies to all staff members (e.g., athletic trainers, physicians, athletic administrators, coaches, strength and conditioning staff, school administrators, advisors) of St. Paul's School who are associated with activities where lightning injuries pose a risk. This policy also applies to athletic participants and spectators of organized events.

5. Procedures:

Monitor Weather Conditions

1. Athletics personnel (athletic trainer, athletic director, coach) must check weather reports each day before any practice or event.

2. Designated personnel (Certified Athletic Trainer) should utilize reliable weather monitoring systems (Lightning Tracker, Weather Channel, AccuWeather, WeatherBug, etc.) to monitor the likelihood for severe weather to enter the area.

Evacuation Criteria

1. The Athletic Trainer will make the decision to evacuate the area. If the athletic trainer is not on site the head coach will make the decision.
2. Lacking reliable, real-time technology that has been independently verified, evacuate when thunder is heard or when lightning is observed "hear it clear it, see it flee it."
3. The coaches will be notified verbally and via text or call by the Certified Athletic Trainer. In the event of an LHSAA sanctioned event, the Officials will also be notified verbally by the Certified Athletic Trainer. This will be discussed in the pregame huddle.
4. All individuals must be cleared from the playing area and play will be suspended when thunder is heard, lightening is seen, and/or the storm is within 10 miles of the playing field. (If an event is being played at night, there may be cases where lightning will be seen from distant storms and a threat is not posed. If thunder is not heard and a lightning/ storm tracker shows the storm is not an eminent danger (within 10 miles of the playing field) then you may continue play per NHFS guidelines).
5. Any non-compliance by a head coach will be recorded and shared with the athletic director. The head coach will be advised that the athletic trainer will no longer be present and he (the head coach) now assumes responsibility.

6. The following table provides common alerts for real-time notification of lightning.

Alert	**Meaning** ***Lightning Distance***
"Heads up"	Lightning 20 miles away
"Begin safety procedures and clear the playing field"	Lightning 15 miles away
"You are now in danger; safety procedures should be complete"	Before lightning reaches 10 miles from venue
"All clear"	Lightning has not been detected at 15 miles **and** thunder has not been heard for 30 minutes
If you hear thunder and/ or see lightning clear the field of play and ensure that all participants are in a safe structure.	

Identification of Safe Structures

1. The Athletic Director, Certified Athletic Trainer and Head Coach are responsible for the identification of safe structure for evacuation
    a. A safe structure is identified as a substantial, fully enclosed building with wiring and plumbing
    b. A safe structure may include an enclosed vehicle (e.g. team bus) when not enough (or no) fully enclosed building are an option

Resumption of activities

1. Activities should be suspended until 30 minutes after the last lightning strike is seen **and** after the last sound of thunder is heard
    a. The 30-minute clock restarts for each lightning flash observed and each time thunder is heard

Documentation

1. In the event where the policy and procedure are not followed, the person(s) responsible for evacuation shall document the interaction with the offender (i.e. official, coach, administrator, etc.) informing them of the severe weather and the response to not evacuate.
    a. The documentation shall also include a signature from the offender verifying their decision to not follow policy.

Treatment

1. If an athlete is struck by lightning, healthcare professionals will designate an individual to call EMS and activate Emergency Action Plan Policy (See EAP)
2. Assess the scene and only approach a lightning victim if the area is safe (no danger of lightning to the rescuer)
3. Move patients to a safer structure (if needed)
4. Assess level of consciousness
5. Evaluate ABC's and treat for life threatening injuries until EMS arrives.
    a. An AED should be applied to anyone who appears to be unconscious, pulseless, apneic
    b. Evaluate and treat for possibility of injuries from lightning (fractures, etc.)

Training/Retraining:

Ensure all parents are aware of the lightning policy at the start of the season.

Train your Principle, Disciplinarian, AD, coaches, and student aides annually.

The following personnel have been trained to ensure a safe participation environment for all individuals, coaches, employees and staff mentioned in the Scope section of this document, who are engaged in activities that could put them at risk of lightning related injuries.

This training includes, but is not limited to, the policy and protocols outlined in this document, the prevention and treatment of lightning-related injuries.

St. Paul's School

Concussion Safety Protocol

1. Purpose of policy:

According to the National Athletic Trainers Association (NATA) a concussion occurs when a force is applied both directly and indirectly to the skill causing a rapid acceleration and deceleration causing a change at the cellular level of the brain. When these changes are paired with clinical signs such as headache, nausea, photophobia, phonophobia, nystagmus, difficulty concentrating, anterograde and retrograde amnesia, loss of balance, mood swings, etc., then a concussion or mild traumatic brain injury is suspected. The athletic trainer is usually the first responders and typically the first to identify and evaluate the injured athlete. It is recommended that athletes undergo a baseline assessment prior to competition to include neurocognitive function as well as motor control. Return to play should be indicated and determined by the overseeing physician. There will be annual training provided to the coaches and parents on concussions.

Refer to:
ksi.uconn.edu, https://www.nata.org/sites/default/files/concussion_management_position_statement.pdf and ITAT

2. Purpose of policy:

According to the National Athletic Trainers Association (NATA) a concussion occurs when a force is applied both directly and indirectly to the skill causing a rapid acceleration and deceleration causing a change at the cellular level of the brain. When these changes are paired with clinical signs such as headache, nausea, photophobia, phonophobia, nystagmus, difficulty concentrating, anterograde and retrograde amnesia, loss of balance, mood swings, etc., then a concussion or mild traumatic brain injury is suspected. The athletic trainer is usually the first responders and typically the first to identify and evaluate the injured athlete. It is recommended that athletes undergo a baseline assessment prior to competition to include neurocognitive function as well as motor control. Return to play should be indicated and determined by the overseeing physician. There will be annual training provided to the coaches and parents on concussions.

Refer to:
ksi.uconn.edu, https://www.nata.org/sites/default/files/concussion_management_position_statement.pdf and ITAT

3. **Policy statement:**

This policy describes the best practice procedures for the prevention, monitoring, and treatment of traumatic brain injuries/ concussions for students/athletes, faculty and staff of St. Paul's School.

This policy will be a living, working document that is continually reviewed and updated yearly as the organization and our community changes.

4. **Pre-participation assessment:**

a. Each student-athlete should receive at least on pre-participation concussion baseline assessment preferably when they first begin sports at St. Paul's School, 9th grade year and 11th grade year. The assessment will be an ImPact test provided and monitored by the onsite athletic trainer with the written consent of the parent/ guardian.

5. **Recognition of Concussion:**

a. Any student-athlete with signs and symptoms will be removed from play and assessed by the athletic trainer.
   aa. Complete the on-field SCAT form and VOMS post competition (recommended), rule out c-spine and skull fracture
   bb. Remove from play if a concussion is suspected
   cc. Inform parents and assist in scheduling a follow up with the concussion clinic or team physician
   dd. Monitor and if symptoms worsen send to the ED

6. **Procedures:**

a. After the athlete has been evaluated by a physician complete post-concussion assessment
   aa. ImPact
   bb. Post-Concussion Inventory Rating Scale
   cc. Follow return to learn and play protocol

Name: _____ **Gender:** _____ **DOB:** _____ Age: _____

School: _____ **Grade:** _____ **Sport:** _____

Today's Date/Time: _____ **Injury Date/Time:** _____

Mechanism of Injury: □ Head to Head/Body □ Head to Ground/Object □ Other: _____

□ Game □ Practice □ Other: _____

Loss of Consciousness: □ Yes □ No Duration: _____

BACKGROUND

Previous Concussions: □ Yes □ No Date(s): _____

How long was the recovery from most recent concussion? _____

Have you ever been hospitalized or had medical imaging done for a head injury? □ Yes □ No

Have you ever been diagnosed with headaches or migraines? □ Yes □ No

Do you have a learning disability, ADD/ADHD or dyslexia? □ Yes □ No

Have you ever been diagnosed with depression, anxiety or other psychiatric disorder? □ Yes □ No

Has anyone in your family ever been diagnosed with any of these conditions? □ Yes □ No

Are you on any medications? If yes, please list: _____

NEUROLOGICAL SCREENING	
Recollection of Injury - Pre/Post-Injury Amnesia	Coordination and Functioning
Strength (Myotomes)	Cranial Nerves and PEARL
Sensation (Dermatomes)	Patient's Relevant Medical History
Findings:	

BALANCE ASSESSMENT		
Foot Tested: □Right □Left	*Footwear:*	*Floor Surface:*
Condition		**Total Errors**
Double Leg Stance		
Single Leg Stance (non-dominant foot)		
Tandem Stance (non-dominant foot in back)		
Types of Errors: Hands lift off iliac crest; Open eyes; Step, stumble, or fall; Moving hip into >30° of abduction; Lift forefoot or heel; Remain out of position >5sec		
Total Balance Errors:		
Impression:		□ Normal □ Abnormal

ImPACT

COMPOSITE SCORES

	Baseline	Post-Injury 1
Memory composite (verbal)		
Memory composite (visual)		
Visual motor speed composite		
Reaction time composite		
Impulse control composite		
Total Symptom Score		
Cognitive Efficiency Index		

SAC

IMMEDIATE MEMORY

All 3 trials are completed regardless of score on trial 1 & 2; score equals sum across all 3 times.

Word List	Alt List	Alt List	Trial 1		Trial 2		Trial 3	
Elbow	Candle	Baby	0	1	0	1	0	1
Apple	Paper	Monkey	0	1	0	1	0	1
Carpet	Sugar	Perfume	0	1	0	1	0	1
Saddle	Sandwich	Sunset	0	1	0	1	0	1
Bubble	Wagon	Iron	0	1	0	1	0	1
Total Immediate Memory Recall:								/15

Note: Do not inform the subject that delayed recall will be tested.

Was not able to ImPACT today due to:
□ Severity of symptoms
□ Other: _____
□ Scheduled to take ImPACT on (Date): _____

ORIENTATION		
Where are we?	0	1
What quarter/ period is it?	0	1
Who scored last?	0	1
Who did we play last game?	0	1
Did we win the last game?	0	1
Orientation Total Score	/5	

CONCENTRATION

Digits Backwards: If correct, go the next string length. If incorrect, read second trial. Stop after incorrect on both trails.

4-9-3	6-2-9	0	1
3-8-1-4	3-2-7-9	0	1
6-2-9-7-1	1-5-2-8-6	0	1
7-1-8-4-6-2	5-3-9-1-4-8	0	1

Months in Reverse Order: Athlete must recite entire reverse sequence correct.

Dec-Nov-Oct-Sept-Aug-Jul-Jun-May-Apr-Mar-Feb-Jan	0	1
Total Concentration Score:	/5	

SAC SUMMARY

Immediate Memory	/15
Orientation	/5
Concentration	/5
Delayed Recall	/5
Total Score	**/30**

SYMPTOM EVALUATION							
	None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6
Vomiting	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Fatigue	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
Sleeping more than usual	0	1	2	3	4	5	6
Drowsiness	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
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervousness	0	1	2	3	4	5	6
Feeling more emotional	0	1	2	3	4	5	6
Numbness or tingling	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling mentally “foggy”	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
Visual problems (double vision, blurring, etc.)	0	1	2	3	4	5	6
Symptom Severity Score:							
Do symptoms worsen with physical activity?				□Yes		□No	
Do symptoms worsen with cognitive activity?				□Yes		□No	
□Self-rated	□Self rated and clinician monitored		□Clinician interview	□Self rated with parent input			
Overall Rating: **How different is the athlete acting compared to his/her usual self?**							
No Different	Very Different		Unsure	N/A			
Out of 100, what percent of Normal do you feel right now?							

MD Referral Made: □ Yes □ No **Spoke with Parent/Guardian:** □ Yes □ No

Concussion Care Handouts Given To: □ Athlete □ Parent/Guardian □Other: _____

ATC Signature:

Name: _____ **Date:** _____

Post-Concussion Symptom Inventory Rating Scale

Instructions: After reading each symptom in the column on the left, please circle the number that best describes the way you/the patient felt before the concussion *(Left Column: Baseline Symptoms)* and then how you/the patient currently feel today *(Right column: Current Symptoms)*. A rating of 0 means you/the patient has not experienced this symptom at all. A rating of 6 means you has experienced severe problems with that symptom. **Answer all items; do not skip any.**

0 = Not a problem 3 = Moderate problem 6 = Severe problem

Symptoms	Retrospective Pre-injury Symptoms							Current Post-Injury Symptoms						
	None	Mild		Moderate		Severe		None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Fatigue	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Visual problems (double vision, blurring,)	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Numbness or tingling	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Vomiting	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Feeling mentally "foggy"	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Feeling more emotional	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Nervousness	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Sleeping more than usual	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Sleeping less than usual	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Feel dazed or stunned	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Get confused with directions or tasks	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Move in a clumsy manner	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Answer questions more slowly than usual	0	1	2	3	4	5	6	0	1	2	3	4	5	6

On a scale of 0% to 100%, what extent are you/patient back to your "typical self?" _____%

No difference 0 1 2 3 4 Major Difference

In general, to what degree do you/the patient seem "different?" That is, not acting like him/herself?

(Circle your rating with "0" indicating "No Difference" and "4" indicating "Major Difference")

St. Paul's School

Pregame Athletic Conference (PAC):

1. PAC Participants
   - Principal (or designee) from both schools
   - Contest officials
   - Security staff from both schools
   - Medical personnel from both schools

2. Roles and locations of persons established should the EAP need to be activated
   - Person designated to provide immediate care of the athlete
   - Person designated to activate (call) Emergency Medical System (EMS)
   - Person designated to retrieve emergency equipment
   - Person designated to meet EMS and direct them to the emergency scene
   - Person designated to control the emergency scene

3. Emergency equipment availability and location at venue identified
   - AED/CPR equipment
   - Exertional heat illness management equipment
   - Lightning detector

4. Emergency transportation logistics discussed
   - What is the planned route for entrance/exit?
   - Is the ambulance a dedicated unit or on stand-by?
   - What if the ambulance leaves the site?
   - If an ambulance is not on site, what is the mechanism for calling one?
   - What is the designated hospital?

5. Weather-related issues discussed
   - Lightning (home team's AT designated to monitor/document)
   - Heat/humidity (FB timeouts)
   - Suspension of play procedures (notifications, shelter sites and directions to sites)

6. Potential impacts to the contest addressed
   - Weather
   - Crowd flow
   - Construction