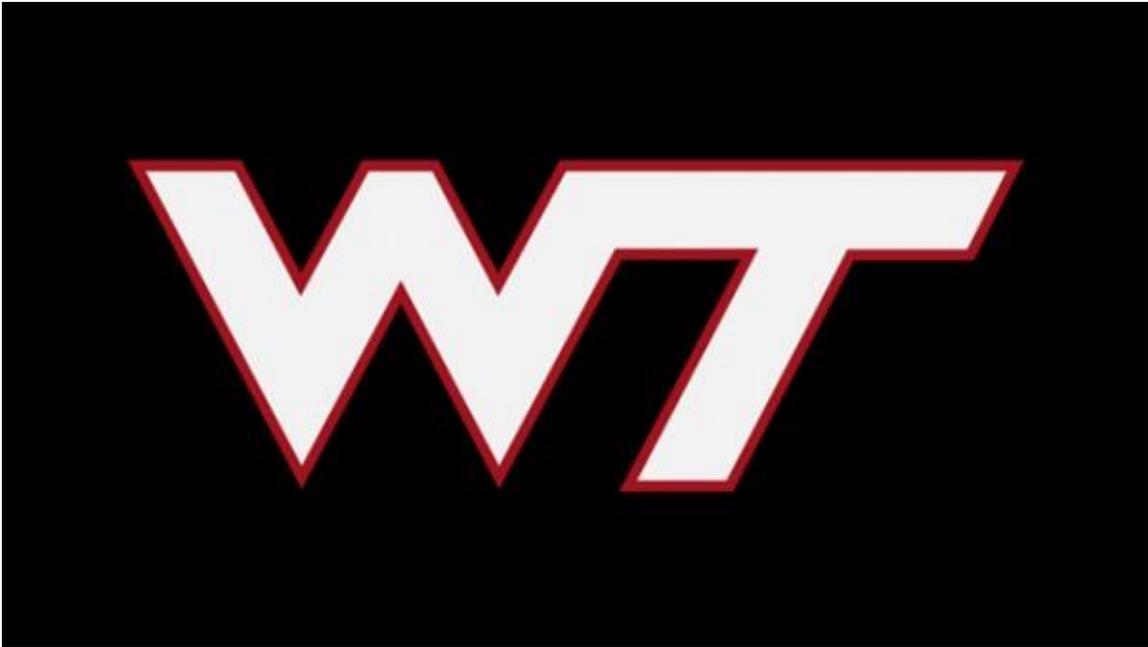


William Tennent High School

Sports Medicine



Policies and Procedures Manual

Including Individual Site

Emergency Action Plans

Table of Contents

Table of Contents.....2

Mission Statements.....3

Physicals.....4

Concussion Guidelines.....5

Cervical Spine Injury Management.....10

Blood Borne Pathogens.....13

Severe Weather Guidelines

 Heat.....14

 Sickle Cell Trait.....18

 Cold.....19

 Lightning.....21

Emergency Action Plan

 Response Protocol.....23

 Contact Numbers.....24

 Personnel & Roles.....25

 Medical Information & Documenting.....27

 Activating EMS.....28

 Serious Injury Guidelines.....29

 Emergency Equipment.....34

 Site Maps.....36

 Individual EAP's.....37

William Tennent Sports Medicine Mission Statement

The mission of the William Tennent Sports Medicine Team is to maintain the health, safety, and welfare of the William Tennent student-athlete through prevention, recognition, evaluation, referral, treatment and rehabilitation of athletic injuries as well as health and wellness education. Our goal is to provide student-athletes with the best health care possible in order to ensure a safe return to athletic competition.

The Sports Medicine team consists of the certified athletic trainer, team physician, physical therapists, athletic administrators, coaches, athletes, and parents. Communication between all members of the sports medicine team is vital to returning the student athlete to activity as quickly and safely as possible. The Athletic Trainer is available at all practices and home events and oversees all athletic injuries. The athletic trainer is an educated medical specialist in the prevention, assessment, rehabilitation and overall management of injuries sustained by the physically active individual. In cooperation with physicians and other allied health personnel, the athletic trainer functions as an integral member of the sports medicine team.

National Athletic Trainers' Association Mission Statement

The mission of the National Athletic Trainers' Association is to enhance the quality of health care for the physically active through education and research in prevention, evaluation, management and rehabilitation of injuries.

Pre-Participation Physical

Initial Evaluation: Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, at any PIAA member school in any school year, the student is required to (1) complete a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) have the appropriate person(s) complete the first six Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, and 5 by the student and parent/guardian; and Section 6 by an Authorized Medical Examiner (AME), those Sections must be turned in to the Principal, or the Principal's designee, of the student's school for retention by the school. The CIPPE may not be authorized earlier than June 1st and shall be effective, regardless of when performed during a school year, until the next May 31st.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: Following completion of a CIPPE, the same student seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year, must complete Section 7 of this form and must turn in that Section to the Principal, or Principal's designee, of his or her school. The Principal, or the Principal's designee, will then determine whether Section 8 need be completed.

Concussion Guidelines

Background:

A concussion is a traumatic brain injury (TBI) caused by a direct or indirect blow to the head or body. The Center for Disease Control and Prevention estimates that as many as 3.8 million sports and recreation related concussions occur in the United States each year. In mid-November of 2011, Pennsylvania Governor Tom Corbett signed the Act of Nov. 9, 2011, P.L. 411, No.101, known as the Safety in Youth Sports Act, into law. This law makes certain requirements of Pennsylvania schools and the personnel who supervise the student athletes who represent these schools, as well as the medical personnel who support them when there is an injury.

Pre-Season Preparation:

Parent / Athlete Education: William Tennent High School has partnered up with St. Mary's Regional Trauma Center to provide concussion education prior to the start of each athletic season to all parents, student-athletes and coaches. It is mandatory for ALL athletes to attend the concussion education presentation and complete the ImpACT test immediately following. Parents are invited to attend the concussion presentation.

Coach Education:

In Compliance with PIAA requirements, once each school year, all William Tennent coaches shall complete the concussion management certification training course offered by the Pennsylvania Athletic Trainers Society and ConcussionWise. This course can be found at <http://www.piaa.org/news/details.aspx?ID=2924>.

Initial Pre-Participatory Physical Exam Form: To compete in athletics at William Tennent, an athlete must submit a completed physical exam form prior to participation. Section 3: Understanding of Risk of Concussion and Traumatic Brain Injury, of the PIAA CIPPE physical form must be signed by both the parent and the athlete prior to participation. Athletes who do not use the PIAA CIPPE form for their physical must receive a copy of Section 3 of the PIAA CIPPE physical form to be signed by both the parent and the athlete prior to participation.

Baseline Testing: All William Tennent athletes will have access to pre-season baseline concussion testing. All participants will automatically receive a baseline concussion test using the ImpACT concussion testing tool.

Concussion Management:

In Compliance with the PA law, "Safety in Youth Sports Act", effective as of July 1, 2012, the Centennial School District has granted authority to all School or Team Physicians and all Licensed Athletic Trainers, to determine that a student athlete exhibits signs or symptoms of a concussion during an athletic contest or practice. All of these individuals have been trained in the evaluation and management of concussion. If the School or Team Physician or Licensed Athletic Trainer is not present at an athletic event or practice, the coach must immediately remove an athlete from play who is exhibiting any of the signs or symptoms of a sports related concussion. The coach must inform one of the William Tennent Licensed Athletic Trainer about the injured athlete so appropriate concussion evaluation can take place. Once the William Tennent School or Team Physician or any of the Licensed Athletic Trainers has determined that a student athlete is exhibiting any of the signs or symptoms of a sports related concussion or other head injury during practice or competition, that student athlete shall be immediately removed from play for the day and may not return to play until he/she is evaluated and cleared for return to participation in writing by an MD / DO or a Neuropsychologist. If an athlete is removed from play to be evaluated for possible concussion signs or symptoms and the Team Physician or a Licensed Athletic Trainer determines that concussion signs or symptoms are not present, the athlete may be returned to play the same day.

Signs of Concussion:

(Could be observed by Coaches, Athletic Trainer, School/Team Physician, School Nurse, Parent / Guardian)

Symptoms of Concussion:

(Reported by the student athlete to Coaches, Athletic Trainer, School/ Team Physician, School Nurse, Parent/ Guardian)

Cognitive Symptoms:

- Difficulty concentrating
- Feeling in a fog
- Trouble Multi-Tasking
- Slowed thinking, acting, reading and speaking
- Difficulty remembering
- Confusion
- Learning/memory trouble
- Loss of memory
- Loss of orientation

Physical Symptoms:

- Headache
- Nausea
- Increased reaction Time
- Lack of energy (Fatigue)
- Difficulty balancing
- Blurred/double vision
- Sleep disruptions/disorders

Social/Emotional Symptoms:

- Irritability
- Anxiousness
- Sadness
- Increased impulsivity
- Social withdraw
- Decreased motivation
- Personality changes

Once a student athlete has been removed from competition or practices because of signs or symptoms of a concussion, the following Concussion Management Protocol must be followed:

1. Emergency medical treatment should be pursued if there is a deterioration of symptoms including seizure, altered level of consciousness, vomiting, altered pupillary findings, or direct neck pain associated with the injury.
2. All appropriate school officials should be notified of the event, including, but not limited to, the school Principal, Licensed Athletic Trainer, Athletic Director, school nurse, school counselor and all of the student's teachers.
3. School officials must make contact with the student athlete's parent/guardian and inform him/her of the suspected sports-related concussion or head injury.
4. School officials shall provide the student athlete and their parent or guardian with information on the continuing care of a person with concussion. This material is available through the Pennsylvania Departments of Health or Education, or the Centers for Disease Control and Prevention (www.cdc.gov).
5. The student athlete must be evaluated by an MD / DO or Neuropsychologist who is trained in the evaluation and management of concussions.
6. The student athlete must receive written clearance from an MD / DO or Neuropsychologist trained in the evaluation and management of concussions that states that the student athlete is asymptomatic at rest and may begin a graduated return-to-play protocol.

Return- to- Play Protocol:

After written medical clearance is given by an MD / DO or Neuropsychologist, the student athlete may begin a graduated individualized return-to-play protocol supervised by a Licensed Athletic Trainer. If an MD / DO or Neuropsychologist clears a concussed athlete for return to play prior to the completion of the 5 Step Return-To-Play protocol, the concussed athlete must complete the 5 Step Return-To-Play protocol. The Student-Athlete must not complete more than one step every 24 hours.

The William Tennent Sports Medicine staff uses the following graduated return to play protocol:

Step 1: Light aerobic exercise- 5 to 10 minute light jog; no weight lifting, resistance training, or any other exercises.

Step 2: Moderate aerobic exercise- 15 to 20 minutes of running at moderate intensity followed by calisthenics and sports specific change of direction grids.

Step 3: Moderate aerobic exercise- 15 to 20 minutes including sprinting exercises followed by sports specific change of direction grids and functional testing.

Step 4: Non-contact training drills in full uniform. May begin weight lifting, resistance training, and other exercises.

Step 5: Full return to activity if asymptomatic following functional testing.

The athlete will be neurologically evaluated each day prior to and after completing each step of the Return to Play Protocol. If concussion symptoms recur during the graduated return-to-play protocol, the student athlete will return, at a minimum, to the previous level of activity that caused no symptoms, and the attending physician should be notified.

The Student-Athlete will not be cleared to participate in a game until he has completed the full Return to Play Protocol which means that they must participate in a full-contact practice. They will not be cleared to play in a game until the athlete has done so

Return to Learn:

Temporary learning support accommodations may be needed for student athletes with Sports-Related Head Injuries to return to the classroom.

Rest is the best “medicine” for healing concussions or other head injuries. The concussed brain is affected in many functional aspects as a result of the injury. Memory, attention span, concentration and speed of processing significantly impact learning. Further, exposing the concussed student athlete to the stimulating school environment may exacerbate symptoms and delay the resolution of symptoms needed for recovery. Accordingly, consideration of the cognitive effects in returning to the classroom is also an important part of the treatment of sports-related concussions and head injuries.

All William Tennent athletes who are diagnosed with a concussion are referred to the William Tennent concussion management team

Second-Impact Syndrome:

A deadly condition resulting from an early return to participation. It occurs when a compromised brain receives a secondary force that prompts immediate and rapid swelling of the brain. A recently injured brain is more susceptible to injury and it only takes a minimal amount of force to cause irreversible damage. This swelling often proves fatal and the mortality rate of second impact syndrome is approximately 50%. Second Impact Syndrome is an emergency situation that must be treated promptly and correctly. Student-athletes, coaches and parents need to be aware of the lethal consequences of Second Impact Syndrome.

Second Impact Syndrome can usually be avoided through proper diagnosis and treatment and by total compliance on the part of the student-athlete. Failure to follow concussion management policies will greatly increase the risk of Second Impact Syndrome.

Multiple Concussions:

When an athlete has sustained more than one concussion, the athletic trainer should pursue a more conservative return to participation and should be aware of the risk of second-impact syndrome. After multiple sub-concussive and concussive impacts, there is a potential for long-term consequences and symptoms. For these reasons, it is especially important to refer the athlete to a physician experienced in concussion management whenever an athlete with a history of multiple concussions presents with the signs and symptoms:

- Concussions sustained as a result of low or lessening forces
- Increasing severity of symptoms with each successive injury
- Objective or subjective changes in baseline brain function

Cervical Spine Injury Policy

General Information:

Athletic participation is the second most common cause of spinal injury to individuals younger than 30 years of age. The majority of all cervical spinal (c-spine) injury victims have been between the ages of 16 and 30. For these reasons, the risk of cervical spine injury during athletic participation cannot be underestimated. St. Luke's University Health Network's athletic trainers strive to decrease the incidence of these injuries through the use of preventative measures, by properly diagnosing critical injuries of the c-spine and by providing potentially life-saving medical care in situations of c-spine injury.

Prevention:

Not all cervical spine injuries can be prevented, but the use of proper technique in contact and collision sports can significantly decrease the incidence of these injuries. Athletes should be provided with adequate education regarding appropriate technique and care should be taken to ensure that dangerous movements are avoided. For example, spearing should not be encouraged or tolerated in football. Likewise, wrestlers must be cautioned against slamming their opponents.

In sports with protective equipment such as shoulder pads, chest protectors and helmets, it is imperative that equipment is well maintained. Ill-kept equipment can decrease the affectivity of the equipment's use and can prevent the rapid provision of emergency care. Helmets should be recertified on an annual basis and replaced or reconditioned as necessary. Any corroded screws should be replaced immediately.

Preparation:

Prior to each academic year, athletic trainers should discuss c-spine injury protocol with their local EMS providers to ensure that all parties agree on methods of immobilization and transfer. It is advised that each school contact local EMS to discuss on-site ambulances for home football games. Avenue specific Emergency Action Plan should be developed for each venue that is utilized by Freedom High School. Stabilization, transfer and immobilization skills should be practiced on an annual basis.

Diagnosis of Critical Injuries:

During an evaluation of the head or neck, the athletic trainer must be on the lookout for symptoms or situations indicative of a severe cervical spine injury. The presence of any of the following criteria is grounds for initiating this protocol.

Symptoms include:

- An unconscious victim
- Altered levels of consciousness
- Bilateral neurologic complaints (weakness, numbness etc.)
- Significant midline spinal pain (with or without palpation)
- Obvious spinal deformity
- Penetrating injuries to the head or neck which have resulted in neurological deficits

Mechanisms consistent with cervical spinal injuries include the following:

- Falls with evidence of head trauma
- Falls from any height above ground level
- Motor vehicle accident

- Trauma in which the victim was thrown (ex: explosion, pedestrian accident)
- Injury due to lightning or high voltage electricity
- Injuries resulting from swimming or diving
- Near drowning when diving may have been involved
- Injuries in which the mechanism of injury is unknown

Treatment:

When a victim has been identified who may have a cervical spinal injury, the cervical spine must be immediately immobilized by manual stabilization. A complete evaluation should be completed at this time with the initial emphasis on completing a primary survey. Dependent on the results of the primary survey, CPR may be initiated and EMS activated or the examiner may continue with a secondary survey. Should CPR be indicated, the provision of CPR must take precedence over treatment of any c-spine injury.

Guidelines for CPR for a Victim of C-Spine Injury:

- Remove the helmet or facemask of the injured athlete
- If needed, shoulder pads may be removed to deliver better chest compressions (Shoulder pads and helmets in football and ice hockey should never be removed independently from one another. Removal of one requires removal of the other.)
- During rescue breathing, the individual with the highest level of medical training should assume responsibility for delivery of care.
- The jaw thrust technique should be utilized instead of the head-tilt maneuver as it causes less movement to the cervical spine.
 - Advanced airway techniques should be used if an appropriately trained rescuer is present as these techniques cause even less disruption to the cervical spine than the jaw thrust technique.
- During the delivery of CPR, care should be taken to disturb the c-spine as little as possible while still providing quality care.
- The athlete should not be moved unless movement is necessary to provide quality CPR (ex: a prone victim).

Stabilization:

As noted above, manual stabilization should immediately be applied to any athlete who may have sustained a cervical spinal injury. Appendages and the cervical spine may be moved into a neutral position in order to decrease secondary injury and to allow for proper delivery of emergency care. If cervical spine realignment causes increased pain, neurologic symptoms, muscle spasm or airway compromise, the realignment is contraindicated. Realignment should also be stopped if there is resistance or the athlete voices apprehension.

Immobilization and Transfer:

If the secondary survey indicates that a c-spine injury is present, EMS will be activated while stabilization is maintained, vital are monitored and CPR is administered (if necessary). The on-site medical personnel (Athletic Trainers) will maintain c-spine stabilization until EMS arrives and the athlete can be transferred to a spine board.

An appropriately sized cervical collar should be placed on the athlete prior to transfer and the head and trunk should be moved as a unit during transfer onto the spine board. The rescuer providing c-spine stabilization will be in charge of facilitating the transfer and will

relay all commands. Transfer may be performed using the log-roll technique or the lift and slide technique. Once the transfer is complete, the athlete should be immobilized and secured to the spine board using straps and foam blocks etc.

Removal of Equipment (Football and Ice Hockey):

Removal of the helmet and shoulder pads may cause undesirable movement of the cervical spine, so appropriate care must be taken during removal. When possible, the helmet and shoulder pads SHOULD NOT be removed until the athlete has been transported to an emergency facility. They may be moved prior to transfer upon the agreement of EMS and the athletic trainer under certain circumstances:

- If the helmet is improperly fitted and therefore cannot stabilize the head
- If the positioning of the equipment prevents airway access or neutral alignment of the spine
- An airway cannot be maintained even after the facemask has been removed
- The facemask cannot be removed after a reasonable period of time

The helmet and shoulder pads should never be independently removed from one another, as this may cause dangerous mal-alignment of the spine. Athletic Trainers must be comfortable with techniques required for removal of all equipment used by their teams.

Facemasks should always be removed prior to transport of the injured athlete, regardless of their current respiratory state. Doing so allows for rapid airway management during transportation, should the need arise. Facemasks should be completely removed, not retracted. Equipment for facemask removal (Trainers' Angels, Cordless Drill, FM Extractor etc) should be readily available and athletic trainers should be familiar with their use. It is advisable to have a backup method or removal available.

If the helmet and shoulder pads must be removed, c-spine stabilization must be preserved during and after removal. The style of helmet and shoulder pads will dictate the manner in which equipment is removed, but it may be helpful to deflate or remove cheek padding prior to helmet removal.

Removal of Equipment (Lacrosse, Field Hockey, Baseball, Softball etc):

Due to the extreme variances of protective equipment in these sports, no generalized recommendation can be made regarding equipment removal. When treating an athlete with a c-spine injury, the primary treatment goals are to ensure proper alignment of the c-spine and to subsequently immobilize the area. If the equipment hinders any of these goals, it should be removed. At all times, proper alignment of the spines should be maintained.

Blood-borne Pathogens Guidelines

This relates to the handling of any bodily fluids, including saliva and blood products. It relates to the potential for blood-borne pathogens in any of these fluids, and how it is to be handled. Any contact with these fluids is to be handled as a potential blood-borne pathogen. Universal precautions are detailed as follows:

1. Any time the athletic trainer is aware there will be contact with bodily fluids; he/she must wear clean gloves and utilize gauze pads (when available) for initial contact on the wound.
2. All bandages, gloves, and all other paper products coming in contact with the wounds/bodily fluids should be disposed of in red biomedical waste bags and properly disposed of via biomedical waste disposal procedures.
3. Any clothes stained with blood, or blood products, should be immediately washed/scrubbed prior to further use. When possible a replacement clothing item should be utilized with the contaminate clothing bagged until cleansing can occur
4. Bandages should be applied to wounds such that exposure to other players is avoided.
5. With any contact with wound or bodily fluid, the athletic trainer should immediately clean his/her hands with warm soapy water or anti-bacterial solution as soon as possible after the event. This applies even if gloves were worn during treatment.
6. These rules apply to coaches in those situations for which an athletic trainer is not present

Severe Weather Guidelines

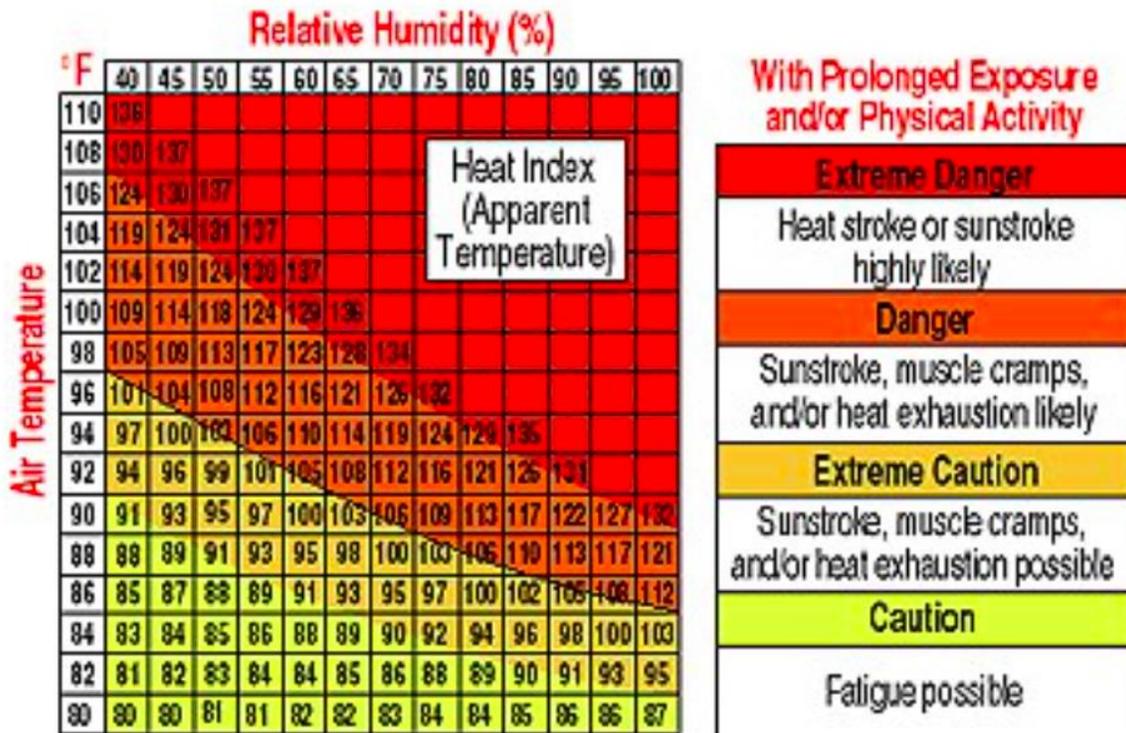
Inclement weather is any type of environmental condition that may put an individual at significant health risk with exposure. This may include excessive heat, cold or thunderstorms.

Heat

Many cases of exertional heat illness are preventable and can be successfully treated if such conditions are properly recognized and appropriate care is given in a timely manner. The Athletic Trainer on site has the authority to alter work/rest ratios, practice schedules, and withdrawal of individuals from participation in sports based on heat conditions and/or athletes' medical conditions. The follow recommendations are provided.

Heat Index Below 95°	<p>All Sports:</p> <ul style="list-style-type: none"> • Provide ample amounts of water. This means water should always be available and athletes should take in as much water as they desire. • Optional water breaks every 30 minutes for 10 minutes duration. • Ice/Cool-down towels for cooling • Watch/monitor athletes carefully for necessary action
Heat Index 95° to 99°	<p>All sports:</p> <ul style="list-style-type: none"> • Provide ample amounts of water. This means water should always be available and athletes should take in as much water as they desire. • Mandatory water breaks every 30 minutes for 10 minutes duration (helmets/shoulder pads removed). • Ice/Cool-down towels for cooling • Watch/monitor athletes carefully for necessary action Football: • Helmets and other possible equipment removed if not involved in contact • Reduce time of outside activity. Consider postponing practice to later in the day • Re-check temperature and humidity every 30 minutes to monitor for increased Heat Index
Heat index 100° to 104°	<p>All sports:</p> <ul style="list-style-type: none"> • Provide ample amounts of water. This means water should always be available and athletes should take in as much water as they desire. • Mandatory water breaks every 20 minutes for 10 minutes duration (helmets/shoulder pads removed). • Ice/Cool-down towels for cooling • Watch/monitor athletes carefully for necessary action • Alter uniform by removing items if possible • Reduce time of outside activity as well as indoor activity if air conditioning unavailable • Postpone practice to later in day if possible Football: • Helmets and other possible equipment removed if not involved in contact

	<p>or necessary for safety. If necessary for safety, reduce time outside and/or suspend activity/practice.</p> <ul style="list-style-type: none"> • Re-check temperature and humidity every 30 minutes to monitor for increased Heat Index
Heat index above 104°	<p>All sports:</p> <ul style="list-style-type: none"> • Stop all outside activity in practice and/or play, and stop all inside activity if air conditioning is unavailable.



Stages of Heat Illness, Warning Signs Treatment, and Return to Activity

Hyponatremia

A potentially fatal illness that occurs when a person's blood sodium levels decrease, either due to over-hydration or inadequate sodium intake, or both. Medical complications can result in cerebral and/ or pulmonary edema. Signs and symptoms of this illness include excessive fluid consumption before, during and after exercising (weight gain during activity); increasing headache; nausea and vomiting (often repetitive); and swelling of extremities (hands and feet).

What to do:

Hyponatremia cases that involve mental confusion and intense headache should be seen by a physician so proper treatment can be administered. A physician should also be consulted prior to resuming outdoor activity in the heat. Always listen to your body. If you are participating in any activity in the heat, and you start to feel ill or strange, you should stop immediately and seek medical attention, as needed.

The athlete should not be allowed to return until his doctor approves and provides specific return to play instructions. The athlete should return to physical activity slowly and under the watchful eye of a trainer or other health care professional.

Heat cramps

Often present in those who perform strenuous exercise in the heat. Conversely, cramps also occur in the absence of warm or hot conditions. Signs and symptoms include intense pain (not associated with pulling or straining a muscle) and persistent muscle contractions that continue during and after exercise.

What to do:

People suffering from heat cramps should cease activity, consume high sodium food and stretch the affected muscle. They should also be assessed by an athletic trainer to determine if they can return to activity. If cramping progresses in severity or number of muscle groups, patients should be transported to the emergency room for more advanced treatment. The athlete can return to play when the cramp has gone away when he/she feels and acts like playing again.

Heat stroke

An extremely serious illness that can result in death unless quickly recognized and properly treated. Signs and symptoms include an increase in core body temperature (usually above 104°F/40°C); central nervous system dysfunction, such as altered consciousness, seizures, confusion, emotional instability, irrational behavior or decreased mental acuity; nausea, vomiting, or diarrhea; headache, dizziness, or weakness; increased heart rate; decreased blood pressure or fast breathing; dehydration; and combativeness.

What to do:

It's very important that treatment for heat stroke be both aggressive and immediate, provided adequate medical personnel are on site. Key steps to take when heat stroke is

identified include immediate whole-body cooling, preferably through cold-water immersion, followed immediately by medical treatment in an emergency room or trauma center.

The athlete should not be allowed to return until his doctor approves and provides specific return to play instructions. The athlete should return to physical activity slowly and under the watchful eye of a trainer or other health care professional.

Heat exhaustion

A moderately serious illness resulting from fluid loss or sodium loss in the heat. Signs and symptoms include loss of coordination; dizziness or fainting; profuse sweating or pale skin; headache, nausea, vomiting or diarrhea; stomach/intestinal cramps or persistent muscle cramps.

What to do:

Heat exhaustion patients should immediately be transported to a cool, shaded environment with feet elevated, and fluids should be replaced. If their condition worsens or does not improve within minutes, they should be transported to the emergency room for evaluation and treatment. Those suffering from heat exhaustion should avoid intense activity in the heat until at least the next day. NATA also recommends a trip to the doctor to rule out any underlying conditions that predispose them to heat exhaustion.

The athlete should not be allowed to play again until all symptoms of heat exhaustion and dehydration are no longer present. Play or practice in the heat should be postponed until at least the next day and possibly longer depending in the severity of the heat exhaustion. If emergency medical treatment was received, the athlete should not be allowed to return without specific return to play instructions from the doctor.

Heat Exhaustion:	Heat Stroke
<ul style="list-style-type: none"> • Heavy sweating • Heavy thirst • Panting/rapid breathing • Rapid pulse • Headache • Blurred vision • Exhaustion, weakness • Clumsiness • Confusion • Dizziness or fainting • Cramps 	<ul style="list-style-type: none"> • No sweating • Red or flushed, hot dry skin • Any symptom of heat exhaustion but more severe • Difficult breathing • Pinpoint pupils • Bizarre behavior • Convulsions • Confusion • Collapse

SICKLE CELL TRAIT

Sickle cell trait is the inheritance of one gene for sickle hemoglobin and one for normal hemoglobin. During intense or extensive exertion, the sickle hemoglobin can change the shape of red cells from round to quarter-moon, or “sickle”. This change, exceptional sickling, can pose a grave risk for some athletes.

The sickle gene is found in approximately 1 in 12 African-Americans, and is also present in those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry. All newborns in the United States are screened for the Sickle Cell trait, but many athletes do not know if they carry the gene or not.

In sickle cell trait, strenuous exercise evokes four forces that in concert foster sickling:

- 1) Severe hypoxemia – decreased oxygen content of arterial blood
- 2) Metabolic acidosis – condition in which the pH of the blood is too acidic due to production of certain types of acids
- 3) Hyperthermia in muscles – elevated body temperature above normal range
- 4) Red-cell dehydration

These may in turn induce acute rhabdomyolysis, a life-threatening condition that will be treated as a medical emergency. In acute rhabdomyolysis, the breakdown of skeletal muscle fibers results in the release of muscle fiber contents into circulation. Rhabdomyolysis may be acute or exertional. All athletes with sickle cell who exhibit any signs or symptoms such as fatigue, difficulty breathing, leg or low back pain, or leg or low back cramping should be assumed to be sickling.

Sickling is often confused with heat cramping; but, athletes who have had both symptoms know the difference, as indicated by the following distinctions:

- 1) Heat cramping often begins with muscle twinges; whereas, sickling has none;
- 2) Pain difference – heat cramping pain is more excruciating;
- 3) What stops the athlete is different – heat crampers hobble to a stop with “locked up” muscles, while sickling players slump to the ground with weak muscles;
- 4) Physical findings are different – heat crampers writhe and yell in pain, with muscles visibly contracted and rock-hard; whereas, sicklers lie fairly still, not yelling in pain, with muscles that look and feel normal;
- 5) The response is different – sickling players caught early and treated right recover faster than players with major heat cramping.

Treatment:

- Check vital signs.
- Cool the athlete, if necessary.
- If the athlete is obtunded or if vital signs decline, activate EMS, attach AED.
- Tell ER to expect explosive rhabdomyolysis and grave metabolic conditions.

COLD

Cold weather is defined as any temperature that can negatively affect the body's regulatory system. These do not have to be freezing temperatures!

When the temperatures drop coaches should perform an indoor warm-up and take the team indoors at the end of practice for team meetings or discussions. Periods of inactivity should also be kept to a minimum during practices below 30°. (In rainy conditions, the above considerations should be taken into account when the temperature drops below 50°). Coaches should make sure athletes are prepared for the temperature and dressed appropriately by keeping track of the forecast not only for the day but for the following day to warn athletes what to expect. The following recommendations are provided

Temperatures with wind chill

30° and below- Warm-ups should be done indoors, possibility of modified practice times

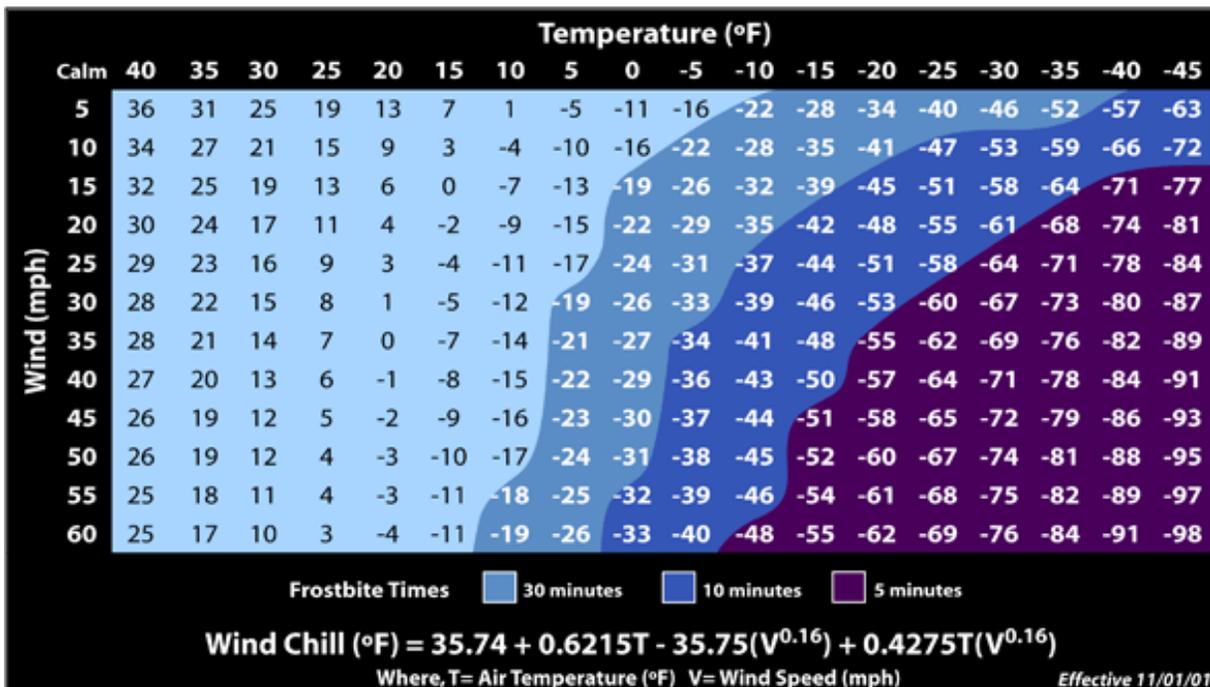
25° and below- No more than 1 hour of outdoor practice. Warm-ups and cool downs should be done indoors

15° and below- No more than 20 minutes of outdoor practice. Warm-ups and cool downs indoors

0° and below- No outdoor practice



Wind Chill Chart



Prevention of cold injuries

- In cold weather temperatures proper layered clothing should be worn. Clothing should be layered to allow adjustments as activity level may increase and decrease within a practice which may elevate or drop body temperature. The first layer of clothing should wick sweat and moisture away from the body. The top layers should act as insulators to trap heat and block wind.
 - Several layers around the core of the body, especially for those individuals that are not very active.
 - Long pants designed to insulate. On very cold days a nylon shell or wind pant can be worn on top of them for additional wind break.
 - Long sleeve shirt/sweatshirt/coat designed to insulate and break the wind.
 - Gloves
 - Ear protection/Hat or helmet.
 - Face protection.
 - Wicking socks that do not hold moisture inside. Wool is excellent. Cotton absorbs and holds in moisture.
- Cold exposure/activity requires more energy from a body. Additional calorie intake may be required.
- Cold exposure/activity requires similar hydration to room temperature; however, the thirst reflex is not activated. Conscious efforts before and after practice to hydrate should be initiated.
- Never train alone. A simple ankle sprain in cold weather may become life threatening!

Signs of Cold Stress

Student athletes should be instructed on signs of cold stress (frost nip, frostbite and hypothermia). Fatigue, confusion, slurred speech, red, swollen, or painful extremities, hard, cold, or waxy skin, blurred vision, red watery eyes, dizziness, headache, numbness, tingling of skin and extremities, shivering, uncontrollable shivering etc. are a few warning signs of cold stress.

The main factors that influence cold stress include: cold weather, wind chill, and dampness/wetness. The combination of cold, wind, and dampness creates an environment that easily predisposes the athlete to hypothermia. Constant adjustment of layers of clothing during activity reduces sweating and the likelihood that the clothing will become damp or wet.

Inadequate clothing, improper warm-up, and a high chill factor form a triad that can lead to musculoskeletal injury, chilblains, frostbite, or minor respiratory disorders associated with lower tissue temperatures. For work or sports in temperatures below 32 degrees Fahrenheit, it is advisable to add a layer of protective clothing for every 5 mph of wind.

Lightning

1. If a severe weather watch or warning is issued you should not be outdoors.
2. Be aware of how close lightening is to your practice area. Use the “Flash to Bang” method.
3. For each 5-second count, lightning is 1 mile away. At a count of 15 seconds (3 miles)
4. If a warning is issued, immediately evacuate all personnel to a safe structure. (a completely enclosed area), staying away from open doors and windows.
 1. A car or bus can act as a “safe location” as long as the windows are closed completely and you stay away from the windows. If no safe structure or location is within a reasonable distance, find a thick grove of small trees surrounded by taller trees or a dry ditch. Assume a crouch position on the ground with only the balls of the feet touching the ground, wrap your arms around your knees and lower your head. **DO NOT LIE ON THE GROUND.**
5. Remain in those structures until the authorities have issued a statement that it is safe to resume outdoor activities.
6. Wait a minimum of 30 minutes from the last lightning strike/visual/sound or until the lightning detector indicates that the storm is no longer a threat. Any subsequent lightning or 30-minute count should reset the clock and another count should begin.

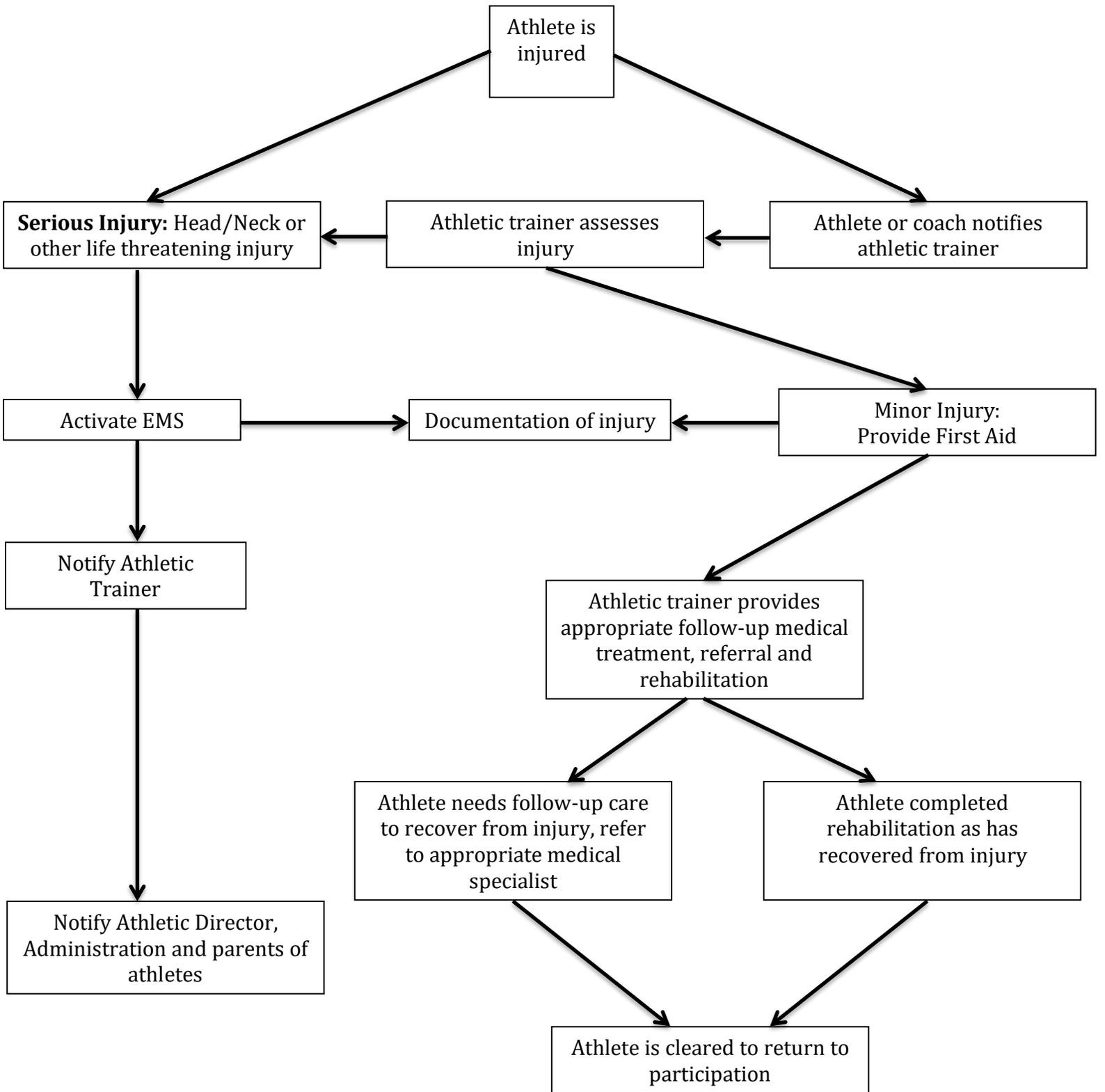
Emergency Action Plan

An Emergency Action Plan (EAP) is set in place to ensure the safety and well-being of all persons in attendance at athletic venues. It sets the standard of care and procedure to be followed in the case of an emergency. EAP's ensure the availability of all the necessary equipment and personnel during an emergency situation.

The EAP set for William Tennent High School has been written specifically for practice and home athletic events. This EAP will set standards to be followed for both life threatening and non-life threatening situations. Components in this document include personnel and their roles, chain of command, equipment, facilities, procedures, maps, emergency contact numbers, medical information and communication instructions.

This plan should be followed to guarantee the safety of all attendees and insure proper care is administered.

Emergency Response Protocol



Contact Information

Team Physician

Dr. Todd Chertow, M.D.
Orthopedic Surgeon and
Rehabilitation associates P.C.
Office- 215-947-6262
Cell- 908-692-8581

WTHS Athletic Trainer

Glenn Watchorn II, MS, LAT, ATC
Office- 215-441-6000 x 12504
Cell- (989) 709-6616

WTHS Athletics

Matt Shade- Athletic Director
Office- 215-441-6000 x 12005
Cell- 267-640-1423

WTHS

Dr. Dennis Best- Principal
Office- 215-441-6000 x 12001
Cell- 215-962-4365

Dr. David Baugh- Superintendent
Office- 215-441-6000 x 11003

Emergency Numbers

Emergency- 911

Warminster Police
215-672-1000

Warminster Ambulance
215-343-2415

Off Site Contacts

Five Ponds Country Club
1225 W. Street Rd
Warminster, Pa 18974
215-956-9727

Pike Lanes Bowling Alley
121 Second Street Pike
Southampton, Pa 18966
215-357-1899

Hospitals

St. Mary's Medical Center
1201 Langhorne-Newtown Rd
Langhorne, Pa 19047
215-947-3000

Holy Redeemer Hospital
1648 Huntingdon Pike
Meadowbrook, Pa 19046
215-947-3000

Doylestown Hospital
595 west State St
Doylestown, Pa 18901
215-345-2200

Abington Memorial Hospital
1200 Old York Rd
Abington, Pa 19001
215-481-2000

Key Personnel and Roles

Medical Personnel:

Team Physician: (Home football games only) Responsible for all medical decisions in the case of an emergency during the care of the student athletes. Football games attendance is required.

Certified Athletic Trainer (ATC): Responsible for the attendance at all practices and home games to provide immediate care and CPR/First aid when the team physician is not present. Also, responsible for assisting with the medical care provided by the team physician

Coaching Staff: In the absence of the ATC, responsible for contacting the ATC and providing immediate care and/or CPR/First aid to the student athlete in the case of an emergency. Certified CPR givers only

Emergency Medical Staff (EMS): Responsible for assisting higher medical personnel with immediate care and CPR/First aid. This group may also be called upon to assist in the activation of EMS in an emergency.

Other Medical Personnel (Athletic Training Students (ATS), fire department, CPR/First aid bystanders): Responsible for assisting higher medical personnel with immediate care and CPR/ First aid. This group may also be called upon to assist in the activation of EMS in an emergency.

Non-Medical Personnel:

Law Enforcement/Event Security: Responsible for crowd control, evacuations and ambulance assistance upon arrival at athletic events.

Custodial Staff/Maintenance: Responsible for allowing access to buildings, doors, gates, etc. Also, responsible for the necessary cleanup of blood, vomit and other materials at athletic events

Administration of Specific Facilities (Five Ponds & Pike Lanes): Responsible in assisting medical personnel with emergency contacts and access to doors, gates, telephones and emergency equipment within your facility. Also providing their facilities own EAP.

School Administration (Principal, Assistant Principals, Athletic director, Teachers): Responsible in assisting medical personnel with emergency contacts, access to telephones, emergency equipment and evacuations of crowds at athletic events. Along with providing William Tennent's, School EAP.

Roles of the First Responders

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, certified athletic trainers, student athletic trainers, coaches, managers, and possibly bystanders. Roles of these individuals within the emergency team may vary depending on various factors such as the number of members of the team, the athletic venue itself, or the preference of the Head Athletic Trainer. There are four basic roles within the emergency medical team.

1. The first and most important role is establishing safety of the scene and immediate care of the athlete. Acute care (immediate care) should be provided by the most qualified individual on the scene. Individuals with lower credentials should yield to those with more appropriate training.
2. 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.
3. Equipment retrieval may be done by anyone on the emergency team who is familiar with the types and locations of the specific equipment needed. Athletic trainers, student athletic trainers, managers, and coaches are good choices for this role.
4. Directing EMS to the scene is the fourth role. One member of the team should be responsible for meeting emergency medical personnel as they arrive at the site of the emergency. Depending on the ease of access, this person should have keys to any locked gates or doors that may slow the arrival of the medical personnel. A coach or facilities manager may be appropriate for this role.

Medical Information

All medical information including copies of emergency contact forms, special cases (allergies, asthma, etc.) and medicine clearance forms (inhalers, epi-pens) will be provided to coaches prior to the beginning of each regular season. It is the coach's responsibility to carry the information at all times during athletic activity including practices, home games and away games.

Documentation:

All actions and treatments pertaining to the emergency situation should be recorded on a standardized form. This is important for future reference for the EAP personnel. They need to be able to look back at the situation and response and improve or revise the EAP as they see fit. This will ensure better reactions and effectiveness for potential emergencies. ATC will be mainly in charge of recording information. Doctors may assist if they provide care or treatment.

Coaches should fill out the William Tennent High School Serious Incident Report.

Documentation should include the following:

1. Documentation of response and actions during emergency situation
2. Follow-up documentation on evaluation of response to emergency situation
3. Documentation of personnel training and rehearsals

All medical records should be kept at the school and copies made to be brought along when traveling.

Activating EMS

CALL 911

In the case of an emergency, do not hesitate to call 911 for any of the following situations.

- Heat Illness
- Catastrophic Head Injury
- Neck or Spine Injury
- Respiratory Difficulties or not breathing
- Fractures/Dislocations
- Severe Bleeding
- Shock
- Loss of Consciousness

Providing Information:

1. Name of caller
2. Address
3. Phone number
4. Number of victims
5. Condition of victims (breathing, not breathing, pulse, no pulse, bleeding, conscious, unconscious)
6. First aid treatment initiated (blood control, rescue breathing, CPR, etc.)
7. Specific directions as needed to location of injured athlete (see individual sport EAP)
8. **DO NOT HANG UP UNTIL INSTRUCTED TO DO SO**

Guidelines during a Serious/Catastrophic On-Field Player Injury:

1. Player and coaches should go to and remain in the bench area once medical assistance arrives. Adequate lines of vision between the medical staffs and all available emergency personnel should be established and maintained.
2. Players, parents and non-authorized personnel should be kept a significant distance away from the seriously injured player or players.
3. Players or non-medical personnel should not touch, move or roll an injured player.
4. Players should not try to assist a teammate who is lying on the field (i.e. removing the helmet or chin strap, or attempting to assist breathing by elevating the waist).
5. Players should not pull on an injured teammate or opponent from a pile-up.
6. Once the medical staff begins to work on an injured player, they should be allowed to perform services without interruption or interference.
7. Players and coaches should avoid dictating medical services to the athletic trainer or team physicians or taking up their time to perform such services.

Life Threatening Situations

1. Activate EMS
 - a. Highest level personnel (person A) present runs out onto the field/court and justifies emergency care is needed
 - b. Person A remains with athlete to administer first aid
 - c. Next level down (person B calls 911)
 - i. Location of phone (see specific venue page)
 - ii. Provide dispatcher with appropriate information
 - d. Person C waits for and directs ambulance to designated area
2. Providing Care
 - a. Person A
 - i. Check the scene
 - ii. Check victim: airway, breathing, circulation (ABC's)
 - iii. Administer care- utilize necessary assistance- person or equipment
 - iv. Provide care until EMS or higher level care is available
3. Direct EMS to scene
 - a. Person C directs ambulance to appropriate entrances (doors, gates, etc.)
4. Crowd Control
 - a. Law enforcement/security should help control the crowd when needed
 - b. If law enforcement/security is not available, coaches, facility administration is responsible.
5. Documentation
 - a. Person A should document the incident in an incident report
 - b. If the ATC did not administer care, they will be available to assist in completing the incident report

Non-Life Threatening Situation

1. Refer student to athletic training room for further evaluation
2. If athletic trainer is unavailable, coaches should initiate first aid
3. Notify athletic trainer of all injuries

Guidelines for Emergency Care to Specific Injuries or Illness

Spinal Injury

1. Check the airway, breathing, and circulation, and administer CPR as needed.
2. Have someone else call 911 (EMS)
3. Support cervical spine by positioning hands on side of head. Do not leave this position until instructed to do so by the EMS crew.
4. Have someone else prevent or treat for shock while you maintain your position at the head.
5. DO NOT ATTEMPT TO MOVE THE ATHLETE unless the athlete is in danger as a result of his/her location. (If the athlete is moved, proper backboard and cervical support must be used)
6. Retrieve oxygen, CPR mask and AED incase needed.
7. Reassure the athlete to stay calm.

Major Fracture/ Dislocations

1. Treat the athlete for shock
2. Apply basic first aid
3. DO NOT ATTEMPT TO REDUCE THE FRACTURE
4. Splint, making sure the athlete continues to have a distal pulse and sensation.
5. Transport the athlete to the hospital.

Heat Illness

1. Remove the athlete from the heat.
2. Remove excess clothing
3. Determine severity of the illness
4. Monitor ABC's
5. Attempt to cool the body (ice bath preferred)
6. Stay with the athlete at all times
7. Call 911 if needed

Cardiac Problems

1. Check the airway, breathing, and circulation, and administer CPR as needed
2. Treat for shock
3. Activate EMS
4. Put athlete in a comfortable position
5. Retrieve oxygen, CPR mask and AED incase needed.

Neck Injury

The following guidelines will be followed to determine EMS transport of suspected spinal injuries. An athlete presenting with one or more of the following will be transported using full spinal precautions.

1. Abnormal level of consciousness or progressive loss of consciousness.
2. Obvious swelling or deformity of the spine.
3. Spinal pain or tenderness.
4. Neurologic signs or symptoms.
5. Pain, stiffness, or neurologic symptoms with active range of motion.
6. Any doubt concerning injury.

General Guidelines

7. Any athlete suspected of having a spinal injury should not be moved and should be managed as though a spinal injury exists.
8. The athlete's airway, breathing, circulation, neurological status, and level of consciousness should be assessed.
9. The athlete should not be moved unless absolutely essential to maintain airway, breathing, and circulation.
10. If the athlete must be moved to maintain airway, breathing, and circulation, the athlete should be placed in the supine position while maintaining spinal immobilization.
11. 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.
12. The Emergency Medical System should be activated.

Face Mask Removal

1. The facemask should be removed prior to transportation, regardless of the current respiratory status.
2. Those involved in the pre-hospital care of injured players of sports that wear helmets/facemasks should have the tools for facemask removal readily available.

Football Helmet Removal

The athletic helmet and chinstrap should only be removed:

- a. If the helmet and chin strap do not hold the head securely, such that immobilization of the helmet does not also immobilize the head.
- b. If the design of the helmet and chin strap is such that even after the removal of the facemask the airway cannot be controlled, or ventilation be provided.
- c. If the facemask cannot be removed after a reasonable period of time.
- d. If the helmet prevents immobilization for transportation in an appropriate position.

Helmet Removal

1. Spinal immobilization must be maintained while removing the helmet.
2. Helmet removal should be frequently practiced under proper supervision.
3. It may be helpful to remove cheek padding and/or deflate air padding prior to helmet removal.

Equipment

1. Appropriate spinal alignment must be maintained.
2. There needs to be a realization that helmet and shoulder pads elevate an athlete's trunk when in the supine position.

3. If a helmet is to be removed, the shoulder pads must be removed and spinal stabilization must be maintained.
4. The front of the shoulder pads can be opened to allow access for CPR.

EMERGENCY EQUIPMENT

ATHLETIC TRAINING ROOMS

1. Vacuum Splints (Leg, Arm, Pump)
2. Cervical Collars (Universal)
3. Knee Immobilizer
4. Crutches
5. Spine Board
6. AED

All Emergency Equipment is available in the Athletic Training Rooms and/or accessible from the Athletic Trainers

Automated External Defibrillator

An automated defibrillator (AED) is a machine that analyzes the hearts rhythm and, if necessary, directs you to deliver a shock to a victim of sudden cardiac arrest. This shock may help the heart to reestablish an effective rhythm.

*Only those certified to use the AED may administer use (ATC, certified persons)

AED Precautions:

- Do not touch the victim while the AED is analyzing or defibrillating
- Do not use alcohol to wipe the victims chest dry or use an AED around other flammable materials
- Do not use an AED on a victim lying on a conductive surface or in water
- Do not use an AED on a child under the age of 8 or under 55 pounds
- Do not use a cellular phone or radio transmitter within 6 feet of the AED

AED's are located at the main entrance of the school, at the top of the main stairs and outside the athletic training room. The athletic trainer will also have an AED that they carry with them to outdoor events.

EPI PENS

This medication is used in emergencies to treat very serious allergic reactions to insect stings/bites, foods, drugs, or other substances. Epinephrine acts quickly to improve breathing, stimulate the heart, raise a dropping blood pressure, reverse hives, and reduce swelling of the face, lips, and throat.

Should only be injected into the middle of your outer thigh (upper leg), through clothing if necessary. Do not inject into your veins, buttocks, fingers, toes, hands or feet. Hold the leg of young children firmly in place before and during injection to prevent injuries

EPI PENS are located on the wall outside of the athletic training room next to the AED

FIRST AID KIT (GIVEN TO EACH TEAM)

1. 1 roll of pre-wrap
2. 2 rolls of white
3. 2 rolls of stretch
4. 2 ice bags
5. 1 6x5" ace wrap
6. 1 4x5" ace wrap
7. 1 2x5 ace wrap
8. 1 8oz hydrogen peroxide
9. 1 4oz hand sanitizer
10. 1 12oz saline solution
11. 4x4" sterile gauze
12. Gloves
13. Cotton rolls
14. Mix of Band-Aids
15. 3x4" non-adherent pads
16. Triple antibiotic cream packets
17. Burn cream packets
18. Sting swabs
19. PAWS
20. Non-sterile tongue depressors
21. Cotton-tip applicators
22. Scissors/Shark

Guidelines to Emergency Care for Specific Locations at WTHS



Gymnasium
(Basketball, Volleyball, Wrestling, Cheerleading)

Emergency Personnel:

-Athletic trainer on site or available for all practices and events

Emergency Communication:

- Coaches should contact athletic trainer via cellphone or walkie-talkie. Landline phone is located in athletic training room

Emergency Response Equipment:

-AED is located on the wall in the hallway outside the athletic training office.

-Spine Board and splints are located in the athletic training room, back left corner behind the desk

-Each team will have and is responsible for their first aid kit

-Athletic trainer will have a first aid kit and AED for all games and practices

Directions

- Instruct EMS to enter school off of Centennial Rd, to the bus loop. EMS can enter school through Cafeteria/Gymnasium entrance. Gym is located down the hallway on the right across from the weight room.

Cafeteria
(Cheerleading)

Emergency Personnel:

-Athletic trainer on site or available for all practices and events

Emergency Communication:

- Coaches should contact athletic trainer via cellphone or walkie-talkie. Landline phone is located in athletic training room

Emergency Response Equipment:

-AED is located on the wall in the hallway outside the athletic training office and on wall next to main entrance.

-Spine Board and splints are located in the athletic training room, back left corner behind the desk

-Each team will have and is responsible for their first aid kit

-Athletic trainer will have a first aid kit and AED for all games and practices

Directions

- Instruct EMS to enter school off of Centennial Rd, to the bus loop. EMS can enter school through Cafeteria/Gymnasium entrance. Cafeteria is located on the right directly after entering through doors.

Pool
(Swimming and Diving)

Emergency Personnel:

-Athletic trainer on site or available for all practices and events

Emergency Communication:

- Coaches should contact athletic trainer via cellphone or walkie-talkie. Landline phone is located in office.

Emergency Response Equipment:

-AED is located on the wall in the hallway outside the athletic training office.

-Spine Board and splints are located in the athletic training room, back left corner behind the desk

-Each team will have and is responsible for their first aid kit

-Athletic trainer will have a first aid kit and AED for all games and practices

Directions

- Instruct EMS to enter school off of Centennial Rd, to the bus loop. EMS can enter school through Cafeteria/Gymnasium entrance. Pool is located down the hallway on the left, right after the weight room.

- To access pool deck, take elevator located by main entrance up to floor 3.

Wrestling Room/ Axillary Gym
(Wrestling, Baseball, Softball)

Emergency Personnel:

-Athletic trainer on site or available for all practices and events. Team physician will be present for home football games.

Emergency Communication:

- Coaches should contact athletic trainer via cellphone or walkie-talkie

Emergency Response Equipment:

- -AED is located on the wall in the hallway outside the athletic training office and on wall outside of 10th grade office.

-Spine Board and splints are located in the athletic training room, back left corner behind the desk

-Each team will have and is responsible for their first aid kit

-Athletic trainer will have a first aid kit and AED for all games and practices

Directions

- Instruct EMS to enter school off of Centennial Rd, to the bus loop. EMS can enter school through Cafeteria/Gymnasium entrance. Elevator is located by main entrance; take up to level 5 to access wrestling room and axillary gym.

Alumni Stadium
(Football, Track, Boys and Girls Soccer, Field Hockey)

Emergency Personnel:

-Athletic trainer on site or available for all practices and events. Team physician will be present for home football games.

Emergency Communication:

- Coaches should contact athletic trainer via cellphone or walkie-talkie

Emergency Response Equipment:

-Each team will have and is responsible for their first aid kit

-Athletic trainer will have a first aid kit and AED for all games and practices

Severe Weather

-Report to school through doors A140 located at the top of the hill.

Directions

-Instruct EMS to enter school off of Centennial Rd, through bus loop and down access path towards the stadium. Ambulance can enter stadium through gates on the west side of stadium.

Tennis Courts

Emergency Personnel:

-Athletic trainer on site or available for all practices and events. Team physician will be present for home football games.

Emergency Communication:

- Coaches should contact athletic trainer via cellphone or walkie-talkie

Emergency Response Equipment:

-Each team will have and is responsible for their first aid kit

-Athletic trainer will have a first aid kit and AED for all games and practices

Severe Weather

-Report to school through doors

Directions

-Enter school off of centennial Rd through the student/teacher parking entrance. Instruct ambulance to come around to back of school towards the tennis courts.

Football Practice Field

Emergency Personnel:

-Athletic trainer on site or available for all practices and events

Emergency Communication:

- Coaches should contact athletic trainer via cellphone or walkie-talkie

Emergency Response Equipment:

-Each team will have and is responsible for their first aid kit

-Athletic trainer will have a first aid kit and AED for all games and practices

Severe Weather

-Report to school through doors A140 located at the top of the hill.

Directions

-Instruct EMS to come down Centennial Rd turning onto Colonial Dr. Ambulance can access football practice field at the end of the street through the parking lot.

Field Hockey Field

Emergency Personnel:

-Athletic trainer on site or available for all practices and events

Emergency Communication:

- Coaches should contact athletic trainer via cellphone or walkie-talkie

Emergency Response Equipment:

-Each team will have and is responsible for their first aid kit

-Athletic trainer will have a first aid kit and AED for all games and practices

Severe Weather

-Report to school through doors A140 located at the top of the hill.

Directions

-Instruct EMS to come down Centennial Rd towards Colonial Dr. Ambulance can access field hockey field at the end of the street through the parking lot.

J.V. Baseball and Softball fields

Emergency Personnel:

-Athletic trainer on site or available for all practices and events

Emergency Communication:

- Coaches should contact athletic trainer via cellphone or walkie-talkie

Emergency Response Equipment:

-Each team will have and is responsible for their first aid kit

-Athletic trainer will have a first aid kit and AED for all games and practices

Severe Weather

-Report to school through main entrance

Directions

-J.V. Baseball field is accessible off of Centennial Rd.

- For softball fields instruct EMS to enter school off of Centennial Rd, through bus loop and down access path towards the stadium.

Freshman Baseball Field

Emergency Personnel:

-Athletic trainer on site or available for all practices and events

Emergency Communication:

- Coaches should contact athletic trainer via cellphone or walkie-talkie

Emergency Response Equipment:

-Each team will have and is responsible for their first aid kit

-Athletic trainer will have a first aid kit and AED for all games and practices

Severe Weather

-Report to Administration building

Directions

-Instruct EMS to enter Administration building entrance off of Centennial Rd. Ambulance will be able to access freshman baseball field behind the building.

Varsity Baseball and Soccer Fields

Emergency Personnel:

-Athletic trainer on site or available for all practices and events

Emergency Communication:

- Coaches should contact athletic trainer via cellphone or walkie-talkie

Emergency Response Equipment:

-Each team will have and is responsible for their first aid kit

-Athletic trainer will have a first aid kit and AED for all games and practices

Severe Weather

-Report to school through main entrance

Directions

-Instruct EMS to turn off of Centennial Rd onto Centennial Station.

Off Campus Facilities
(Five Ponds Country Club and Pike Lanes)

-First aid supplies such as Band-Aids, gloves, etc. are located in the first aid kit at the front at the desk

-Follow facilities EAP

- Notify Athletic trainer

Away Games

-First aid supplies located in teams first aid kit

-Follow facilities EAP

-Notify home school's athletic trainer

-Notify William Tennent athletic trainer