

# **Shepherd High School**



## **Athletic Training: Policy and Procedures Manual**

## Preface

### Statement of Purpose

The following manual has been developed in order to provide a comprehensive informational resource for coaches, parents, student-athletes, and athletic department administrative personnel. The purpose of this manual is to define and delineate the policies and procedures to be used in the day-to-day operation of the Athletic Training program within Shepherd High School. This source is intended to increase the awareness of the policies and procedures used by the McLaren Central Michigan Athletic Training staff and to facilitate communication between the various members of the athletic program and the Athletic Training staff in an effort to provide the most efficient health care to our student athletes.

The Athletic Training program within Shepherd High School is an integral part of the athletic department and serves all athletic participants of Shepherd High School's athletic programs. The Athletic Training staff work closely with athletes, coaches, parents, and administrative personnel to coordinate and implement policies and procedures which allow for the effective delivery of athletic health care. This includes, but is not limited to, the prevention, recognition, evaluation, treatment, and rehabilitation of various athletic-related injuries and/or illnesses.

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# 1. Administrative Issues

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## 1.1. Personnel and Duties

McLaren Central Michigan has hired a part-time Board of Certification certified (ATC) and Michigan licensed Athletic Trainer (AT) to be contracted out to Shepherd High School. The Athletic Trainer (AT) operates under the direction of a McLaren Central Michigan licensed physician. The Athletic Trainer reports directly to the Athletic Director.

The Athletic Trainer's primary duties and responsibilities are defined by the athletic trainer job description. These responsibilities include, but are not limited to:

1. Provide on-site injury care and evaluation as well as appropriate acute care treatments, follow-up treatment and rehabilitation as necessary for all injuries sustained by student athletes.
2. Coordinate with team physician to provide:
  - a. On site visits to evaluate and treat athletes from all sports when needed
  - b. Follow-up injury care in physician's office as needed
  - c. Reconditioning programs
  - d. Assistance on all matters pertaining to the health and well-being of student athletes
3. Determine when an athlete may safely return to full participation after an injury (following a physician's authorization when needed).
4. Notify parents or legal guardians and recommend appropriate medical care when the ATC deems a significant injury has occurred.
5. Coordinate with paramedic team to provide
  - a. Coverage for home varsity football games
  - b. Defined rolls when Emergency Medical Services (EMS) is called
6. Maintain complete and accurate records of all athletic injuries and treatments rendered
7. Supervise the selection, fitting and maintenance of protective equipment
8. Provide assistance to the coaching staff in the development and implementation of conditioning programs.
9. Supervise the Athletic Training Room (ATR) and inspect the playing facilities along with the coaching staff.
10. Select and maintain athletic training equipment and supplies.
11. Attend clinics and symposiums as a source of continuing education.
12. Other responsibilities as delegated by the team physician

The Athletic Trainer will also abide by and uphold the principles and standards set forth in the NATA Code of Ethics and the Board of Certification (BOC) Standards of Professional Practice.

## 1.2. Athletic Training Coverage

All coaches are required to give the ATC a minimum of 24 hours advance notification when changing the date, time, or location of a scheduled game or practice. Changes or notifications made after the specified time frame may result in limited or no coverage, depending on availability.

### 1.2.1. Practice Coverage

The ATC will be on site for most scheduled practices. The ATC will either be in the athletic training room, providing treatment for those athletes who are unable to participate, or--if multiple practices are occurring at the same time--the ATC will be located at the venue with the highest risk sport.

### 1.2.2. Game Coverage

The ATC will be on-site for all scheduled home games, unless these home games interfere with an away varsity football game. During home games, the ATC will be located at the venue with the highest risk of injury. If at any time an injury occurs at the location of a second home event, a coach or the Athletic Director will be responsible for contacting the Athletic Trainer, who will come to the site of injury as soon as possible (see 1.3.2 for injury management at a home event and the Athletic Trainer is not present).

### 1.2.3. Travel Coverage

At this time, the Athletic Trainer only travels with varsity football. Football has the highest incidence of injury and thus requires immediate on-site care from the Athletic Trainer. All coaches with other sports will carry a medical kit for that team during travel (see 2.4.1).

### 1.2.4. Physician Attendance / Paramedic Coverage

Coverage by physician and/or paramedics at home events is presently limited to football games. This is based on the probability of catastrophic injury being significantly higher in this activity.

However, during the fall season, if there is a conflict between an away varsity football game and a home boys' soccer game, the Athletic Trainer will travel with varsity football, and paramedics may be present at the home boys' soccer game.

## 1.3. Injury Management

### 1.3.1. AT Present

In the event an injury occurs while the AT is present at either a home or away events, the following protocol exists:

- a. The AT performs an immediate evaluation of the injury and determines the severity.
- b. An evaluation or an impression is made which forms the basis of the immediate first-aid and continued participation status.
- c. In the absence of a physician, the determination of a student athlete's ability to continue is made solely by the AT.
- d. Should the injury warrant immediate medical attention, the AT will decide on the best means of transportation.
- e. A student athlete sustaining an injury, but continuing to participate will undergo a comprehensive examination at the earliest possible moment, immediately following the practice or game in which the injury occurred.
  - i. The purpose of this exam is to completely evaluate and document the injury and to determine further treatment and the need for medical referral.

### 1.3.2. AT Not Present – Home Event

In the event of an injury at a home event, when the AT is not present, the following procedure exists:

- a. If the AT is on campus, but not immediately present, the coach should contact the AT by the quickest available means, and the injury should be managed as discussed in the previous section.
- b. If the AT is NOT on campus, the attending coach makes an immediate general determination of the severity of the injury and provides any indicated first-aid.
- c. If there is any doubt as to the severity of the injury, medical referral is advised and, if deemed necessary, paramedics should be summoned.
- d. The coach is expected to communicate with the AT that an injury occurred and any further information that may arise.

### 1.3.3. AT Not Present – Away Event

In the event of an injury at an away event, when the AT is not present the following procedure should be followed:

- a. The attending Coach must adhere to the recommendations of the host AT or licensed medical personnel.

- b. All Head Coaches should carry a first aid kit when traveling (see 2.4.1). Immediate first-aid is the responsibility of the Coach until such assistance can be obtained. The Coach should work with the host schools' medical personnel to ensure any necessary immediate medical attention is summoned.
- c. The coach is expected to communicate with the AT that an injury occurred and any further information that may arise.
- d. The injured athlete should be directed to see their home AT as soon as possible before the next practice or contest.

#### 1.3.4. Physical Education (PE) Injuries

- a. All injuries sustained while participating in PE classes are reported to and managed by the school nurse.
- b. If needed, assistance from the AT is available.

### 1.4. Medical Documentation and Confidentiality

#### 1.4.1. Medical Documentation

The Athletic Trainer will keep record of all injuries, illnesses, and surgical procedures along with daily injury records and daily treatment records.

##### 1.4.1.1. Injury / Treatment Files

All injuries must be documented using an *Injury Evaluation* Form. This information is confidential. Only pertinent information may be released to the current coach regarding the injury and treatment rendered.

Any injury that is severe enough to warrant the *Emergency Action Plan* protocol to be administered must be documented and filed with the injury report.

##### 1.4.1.2. Daily Treatment Log

A paper Treatment Log is used to record every visit to the athletic training room including, but not limited to evaluations, treatments, rehabilitation, and taping. Athletes are expected to sign in anytime they are receiving treatment.

##### 1.4.1.3. Coaches' Reports and Injury Status Updates

Coaches' reports are based on direct verbal communication. The Athletic Trainer will act as a liaison for the injured athlete. The athlete is not expected, or trusted, to be able to communicate medical information to the coach. The Athletic Trainer will contact the coach as soon as it is feasible and explain the current and future state of the injured

athlete, including but not limited to: participation status and limitations, game status, and recovery time. If requested, coaches may also receive reports via email, phone call, or text message regarding the status of their athletes.

#### 1.4.1.4. Referral

When the athletic trainer finds that it is necessary to refer an athlete for a follow-up evaluation, the Athletic Trainer may suggest the athlete is seen at Central Michigan Orthopedics. This allows for continuity of care, increased speed of referral and maintains the communication of the athlete's health. However, the parent/guardian may choose their own preferred physician over the Athletic Trainer's suggestion due to personal or insurance reasons. The athlete must return with a note signed by the provider seen (see 1.4.1.5). The athletic trainer will be the only party that refers an athlete.

Athletes who decide to visit a physician without prior knowledge from the Athletic Trainer risk missing competition time. Therefore, it is advised that all athletes report to the Athletic Trainer prior to seeing a physician. Emergency situations are exempt.

#### 1.4.1.5. Medical Clearance to Participate from MD, DO, PA-C, NP

If at any time an athlete needs to be seen by a physician (MD, DO, PA-C, NP) the athlete is not cleared to participate in practice or competitions until he/she returns a medical clearance note to the athletic trainer releasing them for clearance in physical activity. The preferred method is the *Physician Referral Form*, but any note signed by the physician will be accepted. No verbal notes will be accepted from student-athletes or their parents.

Medical clearances will not be accepted by physical therapists (PT, DPT, MPT, etc.), physical therapy assistants (PTA), chiropractors (DC), or other licensed healthcare practitioners.

### 1.4.2. Confidentiality

All of the information gathered and kept private by the Athletic Trainer is highly confidential and is protected by the Federal Education Right to Privacy Act (FERPA) and Health Information Portability and Accountability Act (HIPAA). Unless other arrangements are made, no information regarding the health status of any student-athlete will be released by the Athletic Trainer.

## 2. Athletic Training Room Rules & Regulations

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### 2.1. Athletic Training Room Rules

All student-athletes attending Shepherd High School and participating on its athletic teams are eligible to receive free services from the Athletic Trainer the preset hours of operation.

- a. No one is to be in the athletic training room without the permission of the Athletic Trainer. No student-athletes are to be in the athletic training room without the Athletic Trainer present.
- b. No coaches or administrators will allow student-athletes into the athletic training room without direct supervision.
- c. No equipment or supplies in the athletic training room may be utilized and/or taken from the athletic training room by any sports team, coach, or athlete without permission from the athletic trainer.
  - i. Equipment issued to an athlete by the athletic trainer will be documented.
- d. The athletic training room is an equal access facility; student-athletes will be treated on a first-come first-served basis (except for emergencies). Exceptions to this rule:
  - i. One student-athlete has a practice time earlier than another.
  - ii. Athletes preparing for a game are given priority over practice athletes.
  - iii. In-season sports are given priority over off-season sports.
- e. Cussing, swearing, or foul language will not be tolerated. Actions should be respectful.
- f. The athletic training room is a coed facility. Appropriate attire should be worn at all times.
- g. The athletic training room is not a hang out area. Horseplay is not tolerated and student-athletes may be asked to leave if behavior is not respectful.
- h. No cleats and/or shoes with grass and/or mud are to be worn in the athletic training room.
- i. Shoes are not to be placed on the treatment tables.
- j. All athletes must sign in before receiving ice, tape, or treatment.
- k. No food or drinks are allowed in the athletic training room (water is ok).

### 2.2. Use of the Athletic Training Room

The Athletic Training Room is available for use by all Shepherd High School student-athletes. The facilities are also available for use by members of visiting teams during Shepherd High School home events. Appropriate care and treatment will be provided for athletes in all Shepherd High School sports whenever possible. The athletic training room is an equal access facility; athletes will be treated on a first-come first-served basis. Exceptions to this rule include:

- a. One athlete has a practice time earlier than another.
- b. Athletes preparing for games are given priority over practice athletes.
- c. ***Emergency situations will take precedence over all others.***

The Athletic Training Room must be locked whenever the Athletic Trainer is either off campus or covering another venue. No one is allowed to use the Athletic Training ROOM without the prior knowledge and approval of the Athletic Trainer.

## 2.3. Athletic Training Room Schedule

The Athletic Training Room will be available to all student-athletes Monday through Friday from 3:00pm to the start of sport practices. Once practices have begun, the Athletic Trainer will be either located in the Athletic Training Room or at the practice site of the highest risk sport.

- The ATR will only be open on Saturdays for scheduled home events, specifically treating the athletes competing on that day.
- For events being held during non-traditional hours, the Athletic Training Room will be open approximately one hour prior to the start time of the event.

Athletes and coaches will only have access to ice, coolers, and first aid supplies (via first aid kits) when the athletic training room is closed.

## 2.4. Treatment Times

The Athletic Training room will be open for taping, pre-game treatments, and injury rehab sessions daily after school only. If an athlete is unable to make it to the Athletic Training Room, he/she must inform the Athletic Trainer at his/her earliest convenience.

Receiving treatment in the Athletic Training Room is NOT an excuse to be late to practice. Tardiness to practice will be handled at the Head Coach's discretion.

If the Athletic Trainer has determined an athlete cannot participate in practice, the athlete must receive approval from his/her Head Coach to miss practice for treatment. If approval is not granted, the athlete will be expected to come in to receive treatment before or after practice.

## 2.5. Equipment Checkout

To help keep track of equipment and supplies, persons/groups needing to borrow equipment (ice chests, coolers, crutches, etc.) for athletic or non-athletic use, should ask the Athletic Trainer for permission prior to the time the equipment is needed. ALL equipment being used should be entered into the *Equipment Check-out* sheet. All items used should be cleaned/washed before

returning. Once the item has been returned, enter the date returned on the *Equipment Check-out* form. The person borrowing the equipment is responsible for returning all equipment handed out. The individual may be charged for replacing any equipment not returned.

### 2.5.1. The First Aid Kit

The first aid kit contains basic first aid supplies used by a coach during practices, home events, and away events. Head Coaches needing a first aid kit should see the Athletic Director to be assigned a kit.

- a. The Head Coach is responsible for bringing the kit to all events--home or away--where the Athletic Trainer will not be directly supervising the event.
- b. The Head Coach is responsible for notifying the Athletic Trainer when the kit needs replenishing.
- c. If more specialized equipment is needed, coaches can request the extra supplies from the Athletic Trainer.
- d. Coaches are NOT allowed to help themselves to supplies without the consent of the Athletic Trainer.

### 2.5.2. Rehabilitation Equipment

- a. Athletic Training Room equipment is available to the student-athletes only with AT supervision.
- b. The Athletic Trainer is responsible for the supervising the Athletic Training Room and the Coach is responsible for the supervision of the weight room.
- c. Student-athletes should not be permitted to work in an unsupervised area.
- d. Any rehabilitation equipment removed from the Athletic Training Room for rehabilitation in the gymnasium(s) should be promptly returned following completion.

### 2.5.3. Emergency Equipment

There are three AEDs available in the high school and at the athletic facilities

- a. The fixed AEDs are located as following:
  - i. Inside the high school, next to the Athletic Director's office.
  - ii. Inside the left door of the football coaches' office.
    1. This AED will be used as a traveling AED during away varsity football games.
- b. The mobile AED is located outside in the southeast corner of the football pole barn during the fall months or the baseball/softball garage during the spring months.

All other major equipment (spineboard, splints, crutches, etc.) will generally be kept in the Athletic Training Room.

#### 2.5.4. Protective Equipment

- a. Taping may be part of the initial treatment for some injuries. However, taping an athlete for an entire sports season is a large expense for dwindling athletic budgets. Athletes will be expected to purchase braces, arch supports or other protective equipment, rather than rely on tape the entire season. (see taping 2.4.5)
- b. Athletes are expected to provide their own ankle braces, knee braces, and other protective equipment.

#### 2.5.5. Taping

- a. The Athletic Trainer will not tape for any reason other than protection or prevention of an injury.
  - i. Aesthetic taping will **NOT** be performed.
- b. If tape support is needed, it will be on an individual basis and applied by the Athletic Trainer to support the athlete from further injury while allowing them to continue play.
  - i. If an athlete requires taping for protection or prevention of an injury, then the athlete must perform rehabilitative exercises to strengthen the area to prevent a recurrence.
  - ii. Coaches are **NOT** allowed to tape any student-athletes.
  - iii. Parents are **NOT** allowed to tape their children or any other student-athletes.
- c. Tape support will be supplied for the student-athlete for two weeks **ONLY**, if needed a brace should be used thereafter (See Protective Equipment 2.4.4)
  - i. Shepherd High School is **NOT** responsible for supplying tape support for an individual athlete for the entire season.
- d. Game day only tapings will **NOT** be performed.

### 2.6. Therapeutic Modalities

At this time, Shepherd High School does not have any therapeutic modalities.

### 2.7. Water

A cooler of ice water will be delivered to each athletic game. Coolers will be delivered to practices per the Athletic Trainer's discretion. All coolers and water bottles should be returned to the Athletic Trainer at the end of the day's practice or game. Student-athletes are encouraged to keep a filled water bottle with them while on campus during the school day to enable them to properly hydrate prior to their particular practice or game.

## 3. Injury Management Procedures

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### 3.1. Injury Management Protocol

The Athletic Trainer has valuable knowledge and experience as it pertains to the initial assessment and management of athletic related injuries. Therefore, it is important that coaches make use of this resource. If a student-athlete is injured or suspected to be injured during a practice or game, the coach must report the injury to the Athletic Trainer. Coaches should not attempt to diagnose or judge the severity of an injury or an athlete's ability to continue participation. If an athlete is sent to the Athletic Training Room to see the Athletic Trainer, the coach should follow-up with the Athletic Trainer that day to receive an update on the athlete's injury status.

If an injury occurs on the field or if an injured athlete reports to the Athletic Training room, the Athletic Trainer will evaluate the injury to determine what course of action needs to be taken. In the event that an athlete requires emergency medical care, first aid will be rendered until EMS arrives and the parents will be contacted as soon as possible.

If an athlete's injury does not require outside medical referral, the Athletic Trainer will complete an *Injury/Illness Evaluation Form*. This form contains information regarding the nature and severity of the injury as well as the Athletic Trainer's recommendations for treatment/care/management of the injury. This form will be filed in the Athletic Training Room (see 1.4.1.1).

### 3.2. Referral to a Physician or Medical Specialist

If the Athletic Trainer is of the opinion that a particular injury requires referral to a medical specialist for further evaluation or treatment, the Athletic Trainer will contact the parents of the injured athlete via telephone or in person in order to make arrangements for that athlete to be seen by the proper medical professional. When feasible, the Athletic Trainer will also send a *Physician Referral Form* with the athlete to the medical specialist. This form should be completed and signed by the treating physician and then returned to the Athletic Trainer. The physicians at Central Michigan Orthopedics serve as our official team physicians. Therefore, this orthopedic group will usually be our first choice should the injury involve the musculoskeletal system (bones, joints, muscles). Parents have the option to take their son/daughter to either their family physician or an orthopedist service other than Central Michigan Orthopedics.

Should a referral be made, the injured athlete will be unable to participate in any athletic activity until written clearance regarding the injury is received and reviewed by the Athletic Trainer. It is the responsibility of the athlete and his/her parents to insure that the physician forwards all requested information.

Coaches do not have the authority to make referrals to any physician without the approval of the Athletic Trainer, except in cases where emergency care is indicated.

### 3.3. Practice and Game Procedures for an Injured or Ill Student Athlete

Decisions regarding the availability of the injured/ill student-athlete for practice or game competition require the cooperative efforts of the student-athlete, Coach, Athletic Trainer, physician, parents, and the AD. These decisions should and will be based on sound medical judgments, with the outcome being proper athletic health care. With this in mind, the AT will attempt to provide quality athletic health care for the student athlete under the following guidelines:

#### 3.3.1. Under the care of a physician

If a student athlete is under the care of a physician, the physician determines the ability of the student-athlete to practice or compete in practice or game. This decision is most often communicated via a physician's note, but can be made in person if the physician is present.

If the athlete has received a clearance note from his/her treating physician, the Athletic Trainer continues to have the right to limit the athlete's participation in practices/games as (s)he sees fit.

#### 3.3.2. Student athlete is NOT under a physician's care

If the student athlete is not under a physician's care and the AT is providing the primary care, the Athletic Trainer determines the ability of the student athlete to practice or compete.

- a. The Athletic Trainer will have the authority to decide the playing status of the injured athlete in regards to injuries not needing medical referral.
- b. The AT will convey a "no-play" decision to the appropriate coach.
- c. Under no circumstances should the coach allow the student-athlete to practice or compete until either they are cleared directly by the Athletic Trainer.
  - i. A "no-play" decision by the physician will always be followed.

- ii. Should a coach or student athlete desire to disregard the “no-play” order (from the Athletic Trainer or physician), action will be taken to safeguard the student athletes’ health.
  - 1. AT will notify the AD of student athletes’ and coaches actions.
  - 2. AT will notify the student athletes’ parents/guardian.
- iii. THE NUMBER ONE PRIORITY OF THE ATHLETIC TRAINER IS THE HEALTH OF THE ATHLETE. IF IT IS UNSAFE FOR THE ATHLETE TO PARTICIPATE OR IT IS DEEMED FURTHER PLAY WILL RESULT IN FURTHER INJURY, THE ATHLETE SHOULD NOT BE PARTICIPATING!!

### 3.3.3. Medical Referral and Continued Care

- a. At the time of the comprehensive examination of the injury, the AT will present his/her opinion on the need of a medical referral.
- b. Parents/guardian will be notified if there is a need for a medical referral.
  - i. The AT will give advice about the type of physician that would best help the student athlete.
  - ii. The AT will give advice about the specific physician that would best help the student athlete.
- c. The final decision rests with the parent/guardian. If the parent/guardian disregards the referral, the student-athlete will be medically disqualified until they are seen by a physician.
- d. If the student athlete receives care from a physician, a completed form or prescription will indicate the diagnosis and suggestions for the continued care of the student athlete. A physician note is required after seeing a physician.
- e. In the event an injured student-athlete sees a physician without prior knowledge of the AT, the athlete must bring a written report of the physician’s finding for the release to play. If this is not provided, the student-athlete will not be permitted to practice/compete until this note is filed with the AT.
- f. Continued care of the student athlete is carried out in the form of daily reevaluation of the student-athletes’ progress, daily treatments, and rehabilitation.
- g. Where needed and available, such care is performed with periodic consultation of the attending physician.

## 3.4. Physical Therapy and Rehabilitation Services

The Athletic Trainer offers rehabilitation services at Shepherd High School. These services are open to all student-athletes and can be used as prevention or treatment of previous or present injuries.

### 3.4.1. Off-site physical therapy services

In some cases, a physician may refer an athlete to an off-site Physical Therapy clinic for rehabilitation. If a referral is made, the athlete will not be expected to continue rehabilitation with the Athletic Trainer until discharged from Physical Therapy. Once discharged, the Athletic Trainer will determine if the athlete must continue rehabilitation in the Athletic Training Room.

## 3.5. Return to Activity Following an Injury

Any athlete who has missed practices or games while under the care of a physician for a particular injury or illness must turn in a written medical clearance from the treating physician to the Athletic Trainer. Athletes who have missed practices or games due to a particular injury or illness should be re-evaluated by the Athletic Trainer BEFORE they are allowed to return to active participation.

Written clearance to participate does not guarantee that the athlete will be able to immediately return to the highest level of activity in their particular sport. Therefore, it is important for the Athletic Trainer to re-evaluate an athlete in order to determine the athlete's readiness to return to activity. This re-evaluation may include functional testing to determine at what level of activity it is safe for the athlete. Coaches must communicate with the Athletic Trainer BEFORE allowing an athlete to return to activity following an injury. Coaches are required to follow the Physician and Athletic Trainer's recommendations for an athlete's participation.

Return to play criteria is a joint decision made by numerous individuals.

- In the event that a licensed medical physician, physician's assistant, or nurse practitioner states that the student-athlete CANNOT return to activity for a certain amount of time or prior to a criteria, then that MUST be adhered to or result in a possible personal liability suit.
- If the athlete has not been referred to or has no direct recommendations from a healthcare professional, the Athletic Trainer will then make the decision as to when the athlete can return to play.
- In the event that a licensed medical physician, physician's assistant, or nurse practitioner states that the student-athlete CAN return to activity, the Athletic Trainer will make the decision as to the extent of participation.
- If any of the following individuals determines that the injured athlete is not fit to return to play or that the athlete's activity level be modified, their decision must be adhered to and the athlete MUST NOT BE ALLOWED TO RETURN TO ACTIVITY or ACTIVITY MUST BE MODIFIED TO MEET THEIR SPECIFICATIONS!

- Return to Play criteria after an athlete has sustained a head injury is solely the decision of the Physician or Athletic Trainer. No exceptions will be made! (see 4.3.1 for Concussion Return to Play Protocol).

## 3.6. Athletic Accident Insurance

At this time, Shepherd High School does not have any secondary insurance covering its student-athletes.

### 3.6.1. MHSAA Insurance

The MHSAA provides accident, medical, and concussion insurance to eligible athletes. Traditional features of this insurance includes:

#### 3.6.1.1. MHSAA Accident and Medical Insurance

- a. Coverage is provided for grades 6-12 for all students accidentally injured while students are engaged in interscholastic athletic activities under the jurisdiction of the Michigan High School Athletic Association; namely: baseball, basketball (boys and girls), bowling (boys and girls), cross country (boys and girls), football, golf (boys and girls), gymnastics (girls), competitive cheer (girls), ice hockey, lacrosse (boys and girls), soccer (boys and girls), softball (girls), alpine skiing (boys and girls), swimming and diving (boys and girls), tennis (boys and girls), track and field (boys and girls), volleyball (girls), and wrestling.
  - i. Sideline cheerleaders are covered while traveling directly to and from interscholastic athletic events as a representative of the school while traveling in transportation sponsored by the school, and while cheering at interscholastic athletic events under the direct supervision of a school employee designated by the school. To be covered by MHSAA-purchased insurance, the activity of sideline cheerleaders at interscholastic athletic events must not exceed the safety norms of MHSAA Girls Competitive Cheer (i.e., the height of mounts, flips, stunts, etc.).
- b. All eligible students who participate in interscholastic athletic activities at an MHSAA member school in sports which end with an MHSAA tournament are covered provided their school principal attests in writing and the MHSAA agrees that they were eligible under all MHSAA regulations at the time of the injury. **Eligible** student athletes are covered while traveling directly to and from a scheduled event as a representative of the school while traveling in transportation sponsored by the school, and while participating in season in an allowed activity under the direct supervision of a full-time school employee or coach designated

by the school acting within the scope of his/her coaching duties in those sports for which the MHSAA provides a tournament series.

- c. Student-athletes ineligible under MHSAA Regulations are not covered.
  - i. Students who are ineligible under local school rules but would be eligible under MHSAA rules would be covered if they were allowed to practice with their school team.
  - ii. Students who are otherwise eligible but are suspended from contests under Regulation V, Section 3 (contest disqualifications) would be covered if they were to continue practicing with the school team
- d. **MHSAA Accident Medical Insurance does NOT cover ANY out-of-season activities or any activities occurring beyond the mileage limits of Regulation II, Section 6, Interpretation 193, even if those activities are not expressly prohibited by the MHSAA.**

This coverage is provided at no cost to the eligible athletes of MHSAA member schools and to registered officials. The MHSAA is the policyholder and pays the premium for this layer of accident medical coverage. The policy will pay up to \$1,000,000 in medical expenses after a deductible of \$25,000 in paid medical expenses per claim has been met. The MHSAA arranged program will then pay medical expenses above the \$25,000 deductible left unpaid by the parents' or official's insurance or any other sources such as school purchased insurance.

A payment of a cash benefit payment of up to \$50,000 will be made if a covered person is paralyzed or in a coma within 180 days after the accident. Payment will not be made until a physician certifies that, after a 16-month waiting period, the injury is permanent and irreversible. This payment is in addition to those payments already covered for medical expenses and must result in disability. This payment is in addition to those payments already covered for medical expenses.

The first medical expense must be incurred within 90 days after the date of the accident. An accidental death or dismemberment benefit of \$10,000 is paid if either event occurs within 365 days of the date.

#### 3.6.1.2. MHSAA Concussion Care Insurance

Since the 2015-16 school year, the Michigan High School Athletic Association has provided athletic participants at each MHSAA member junior high/middle school and high school with insurance that is intended to pay accident medical expense benefits resulting from concussion. The suspected concussion must be sustained while the athlete

is participating in an MHSAA in-season covered activity (in-season practice or competition). Policy limit is \$25,000 for each accident.

Covered students, sports and situations follow to the catastrophic accident medical insurance (see 3.6.1.1).

This program intends to assure that all eligible student-athletes in MHSAA member schools in grades 6-12, male and female, in all levels of all sports under the jurisdiction of the MHSAA, receive prompt and professional attention for head injury events even if the child is uninsured or underinsured. Accident medical deductibles and copays left unpaid by other policies are reimbursed under this program.

## 4. General Injury Care Procedures

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### 4.1. General Emergency Action Plan for Life Threatening Injuries

The primary concern of administering emergency aid to an injured athlete is to maintain cardiovascular function and central nervous system function – the failure of either of those systems may lead to permanent injury or death. To provide the best possible care to our student athletes, coaches and Athletic Trainers must work together as a team. In most situations involving injury or illness to an athlete, coaches are typically the first responder and must be able initiate the Emergency Action Plan (EAP) in the absence of a licensed Athletic Trainer. In the event that a possible life threatening injury or illness occurs without the presence of a medical professional, first responders must remain calm and act quickly in order to facilitate life-saving care.

Time is the most important factor when responding to a serious injury. Due to the immediate contact coaches have with their athletes, initiating the EAP can save an injured athlete valuable minutes.

Having a licensed Athletic Trainer on staff is an asset to an athletic program; it does not eliminate the coach's responsibility to keep their athletes safe nor does it protect them from negligence. Emergency responsibilities for coaches as first responders would include: Contacting emergency medical services (EMS-911), performing CPR, applying a defibrillator, or providing first aid.

#### 4.1.1. Signs or Symptoms of Potentially Serious Injury or Illness

- Changes in skin color (red, pale, or blue) or temperature (hot, dry, cool, or clammy).
- Body temperature that is less than 95 degrees or greater than 102 degrees.
- Changes in breathing (shallow, irregular, or gasping).
- Complaints of head, neck, or abdominal pain after a collision or contact type injury.
- Frothy blood dissipating from the mouth.
- Loss of consciousness.
- No signs of breathing or a pulse.
- Numbness below the neck and difficulty or inability to move extremities.
- Pupils are unequal in shape or fully dilated.
- Uncontrollable bleeding from a laceration or puncture wound.

#### 4.1.2. Head and Neck Injuries

Concussions occur regularly in a collision type sports. Injuries to the head and neck can be catastrophic in nature. If an athlete suffers an injury to the head or neck and there are no medical personnel available, then it is the coach's responsibility to make sure that their athlete receives proper medical care. Always err on the side of caution in regards to a head or neck injury.

Diagnosing a concussion can be very difficult and is often passed over as "just getting his bell rung". "Burners" or "Stingers" can also occur regularly in collision sports and should be treated as a potentially serious nerve injury. Remember, if an athlete is hit hard enough to elicit an ill effect, then it may no longer be safe for that athlete to immediately continue the contest.

Returning to play after a concussion will be determined on a case by case basis, **athletes may return to play only after receiving an official released by their caring physician and by the Athletic Trainer.**

Do not allow the athlete to return to play if he or she is suffering from any of the following symptoms:

- Loss of consciousness (even if for a few seconds). (\*Refer to EAP)
- Numbness, tingling, or burning sensation in the arms or legs.
- Headache, dizziness, ears ringing, confusion, or amnesia. (Do not give medication to the athlete at anytime, use an ice pack to decrease symptoms instead).
- Complaints of pain anywhere on the head or along the spine.

#### 4.1.3. General Emergency Action Plan Protocol \*in the absence of an athletic trainer

Please see the Emergency Action Plan for each specific school for Venue and Injury Specific EAPs

Step 1: \*Activate EMS (call 911) if:

- Changes in skin color (red, pale, or blue) or temperature (hot, dry, cool, or clammy).
- Body temperature that is less than 95 deg or greater than 102 degrees.
- Changes in breathing (shallow, irregular, or gasping).
- Complaints of head, neck, or abdominal pain after a collision or contact type injury.
- Frothy blood dissipating from the mouth.
- Loss of consciousness.
- No signs of breathing or a pulse.
- Numbness below the neck and difficulty or inability to move extremities.
- Pupils are unequal in shape or fully dilated.
- Uncontrollable bleeding from a laceration or puncture wound.

\*\*\* if possible, designate another coach or staff member to do this while you tend to the victim.

Step 2: Communicate information to EMS in this order (speak clearly and calmly):

1. Name of the school, address of the school, and location of incident (i.e. baseball field).
2. Your name and phone number.
3. Description of incident.

Step 3: Call Athletic Trainer and/or Athletic Director

Step 4: If the victim is unconscious:

- Check ABC's (airway, breathing, circulation) and stabilize the head if you suspect a neck injury.
  - If no breathing or pulse is found, apply defibrillator or begin CPR until help arrives (if using defibrillator, follow voice prompts).
  - If breathing, monitor for changes until help arrives.

Step 5: Control severe bleeding by applying direct pressure over or above the wound. Keep athlete calm until EMS arrives.

- Never leave an injured or unconscious victim unattended unless you are the only available person to activate the EAP. You must keep the victim calm and perform life sustaining skills as needed! Every effort must be made for another person to call 911 and to notify the Athletic Trainer of the situation. Remember to use common sense! There is no liability for attempting to provide some sort of medical assistance, but the consequences can be severe if you neglect to do nothing at all.

#### 4.1.4. Duties of the Personnel Involved in the Emergency Action Plan

1. First coach or staff member on the scene will initiate EAP protocol and perform life-sustaining skills as needed and attempt to contact the Athletic Trainer.
2. Upon arrival, the Athletic Trainer will assume control over the incident scene and direct other coaches and or staff members on proper procedures.
3. Whoever is chosen to be the designated caller will also direct (flag down) the ambulance to the location of the incident. If no designated caller is available, the first coach/staff member on the scene will direct EMS to the proper location once he or she has been relieved by the Athletic Trainer to do so.
4. Coaches and/or staff members will also assist the Athletic Trainer by maintaining crowd control if necessary.

## 4.2. Non-Emergent Injuries or Illnesses

Non-emergent injuries to athletes are considered “not life threatening” and have a common place in athletics. Injuries can certainly make an Athletic Trainer’s or coach’s job very difficult because of the uncertainty of the athlete’s condition from day to day, week to week, or even month to month. Rarely can the full recovery from any injury be predetermined. Coaches and parents should understand that there is usually a huge disparity with the physical demands placed on the body when an athlete is participating in practice as opposed to a game. Factors such as an athlete’s health, level of conditioning, nutrition intake, sleeping habits, or compliance with a treatment protocol can affect how quickly an athlete recovers from an injury.

### 4.2.1. Examples of non-emergent injuries or illnesses

- Ligament sprains.
- Muscle strains.
- Most contusions (monitor the athlete if contact occurred to the head, spine, abdomen, or groin).
- Blisters or small lacerations.
- Muscle spasms or cramps.
- Post workout fatigue and soreness.

### 4.2.2. Protocol for handling non-emergent injuries in the absence of the athletic trainer

Step 1: Have the athlete sit and rest, apply ice to the pain site as needed

Step 2: If symptoms do not resolve within 15 minutes, contact the Athletic Trainer.

Notes from physicians or parents should be given to the Athletic Trainer regarding all injuries. All injuries occurring during SHS athletics should be evaluated by the Athletic Trainer – NOT THE SCHOOL NURSE.

## 4.3. Special Considerations

### 4.3.1. Concussion, Second Impact Syndrome, & Return to Play Criteria

Concussion and second impact syndrome are two potentially life-threatening conditions to which student-athletes, especially those involved in contact sports, are exposed. Concussion is a complex injury that is often one of the most difficult to evaluate and manage. Concussion is defined as a traumatic injury. These injuries usually result due to a direct blow to the head, but they may also result due to rapid acceleration/deceleration of the head, thus causing jarring of the brain within the skull.

Second impact syndrome is a sequel that results when an athlete suffers a second, often minor, head injury after returning to activity before the symptoms of a previous concussion have resolved. This secondary injury leads to engorgement of the cranial veins causing severe swelling of the brain. Most cases of second impact syndrome occur in individuals under the age of 18. Second impact syndrome is a serious condition that can be potentially fatal (50% mortality rate).

Shepherd High School considers concussions and second impact syndrome to be significant medical conditions. Therefore, any athlete who suffers a head injury during a practice or game which results in symptoms consistent with those of a concussion, he/she will be required to follow the steps set out in this concussion protocol.

#### 4.3.1.1. Baseline Testing

Baseline tests are used to assess an athlete's normal balance and brain function, including learning and memory skills, ability to pay attention or concentrate, and how quickly he/she thinks and solves problems. Baseline tests scores not considered pass or fail. The score for one athlete will likely differ from the score of another athlete.

All athletes participating in SHS contact sports--football, soccer, cheer, basketball, wrestling, baseball, and softball--will be required to complete a baseline test with the Athletic Trainer prior to the first game/competition of the season.

#### 4.3.1.2. Immediate Referral

In the event a student-athlete presents with these signs or symptoms below, the Athletic Trainer and/or coaching staff will initiate the emergency action plan associated with the current site of participation.

- Uneven pupil size
- Prolonged loss of consciousness
- Decreased consciousness
- Persistently diminished/worsening mental status or other neurological signs/symptoms
- Clear or discolored fluid leaking from eyes, ears, nose or mouth
- Bleeding or bruising from eyes, ears, nose or mouth
- Spine injury or neck pain
- Repetitive emesis (vomiting)
- Seizure
- Trouble recognizing people or places
- Slurred speech
- Weakness in arms or legs

#### 4.3.1.3. Michigan Concussion Law

The Michigan Concussion Law went into effect in June 2013 and was amended in October 2017. This law claims the following:

- Any athlete who is suspected of sustaining a concussion must be immediately removed from play.
- Athletes suspected of a concussion may not return to [ANY] physical activity until he/she receives written clearance from an appropriate medical professional.
  - In the state of Michigan, an athlete may be cleared by an MD, DO, PA-C, or NP.
- All coaches, employees, volunteers, and other adults who are involved in athletic activities must complete concussion awareness training every three years.

#### 4.3.1.4. MHSAA Concussion Requirements

Any athlete diagnosed with a concussion must receive written clearance from the releasing medical professional via the *MHSAA Return to Activity & Post-Concussion Consent Form*. The athlete and his/her parent/guardian must additionally sign this form and return it to the Athletic Director or Athletic Trainer before returning to activity.

Individual schools, districts, and leagues may have more stringent requirements and protocols including but not limited to mandatory periods of inactivity, screening, and

post-concussion testing prior to or after the written clearance for return to activity (see 4.3.2.6 for the SHS Return to Play protocol).

#### 4.3.1.5. Concussion Protocol

Any athlete displaying one or more symptoms will be removed from activity immediately, no exceptions. Common symptoms may include, but are not limited to:

- Headache
- Nausea/vomiting
- Neck pain
- Drowsiness
- Balance problems
- Dizziness
- Fatigue
- Confusion
- Difficulty remembering/concentrating
- Sensitivity to light/noise
- Vision problems
- Nervousness
- Anxiety
- Irritability
- Loss of consciousness\*

\*A concussion can occur even if the athlete does not lose consciousness. Less than 10% of concussions result in loss of consciousness.

1. If the Athletic Trainer is present, a concussion assessment (i.e. *NFL Sideline Concussion Assessment*) and evaluation of the athlete is completed.
  - If the Athletic Trainer is NOT present (i.e. away game, off-campus practice, off-season practice, non-traditional practice time, etc.), the coach will be required to communicate the injury to the ATC via phone call or text message, and the *NFL Sideline Concussion Assessment* will be given at the time of evaluation.
2. The Athletic Trainer will determine to either send the athlete immediately or to be monitored by a parent/guardian at home.
  - Parents/guardians should refrain from taking their child to the Emergency Room or Urgent Care (see 4.3.1.2 for danger signs that warrant immediate referral).
3. If instructed to seek further medical assistance, athletes will be instructed to visit a healthcare professional trained in concussion recognition and management as soon as possible (MD, DO, PA-C, or NP). The Athletic Trainer may suggest the athlete visit SHS's team doctors at Central Michigan Orthopedics, but the parent/guardian may choose to seek attention elsewhere (see 3.2).
  - The diagnosis of a "closed head injury" will be treated the same as a concussion.
  - The diagnosis of "got your bell rung" will be treated the same as a concussion.

4. Following the injury, the athlete will report to the Athletic Training Room on a daily basis to be assessed by the Athletic Trainer and to complete the *Concussion Symptom Checklist*.
5. Once all symptoms are resolved, the athlete will be instructed to follow up with his/her treating physician, and must receive written clearance via the *MHSAA Return to Activity & Post-Concussion Consent Form*. The completed form must be returned to the Athletic Trainer or Athletic Director.
  - The athlete may begin the Return to Play Protocol before his/her follow up appointment but may not return to games/competition prior to complete clearance from the treating physician (see 4.3.1.6 for the complete Return to Play Protocol).

Until written clearance is obtained by the evaluating licensed healthcare provider (MD, DO, PA-C, or NP) and the athlete completes the gradual *Return to Play Protocol*, the athlete will not be allowed to practice, condition, weightlift, or compete.

#### 4.3.1.6. Return to Play Protocol

Every athlete diagnosed with a concussion will be required to complete the Return to Play Protocol once symptoms have resolved, **no exceptions**. This protocol may only be completed under the Athletic Trainer's supervision and will take a minimum of 5 additional days to complete after symptoms are resolved.

<b>Return to Play Protocol</b>	
<b>STAGE</b>	<b>OBJECTIVES</b>
1. No activity	Recovery
2. Light aerobic exercise	Increase heart rate
3. Sports specific exercise	Add movement
4. Non-contact drills	Exercise, coordination, and cognitive load
5. Full-contact practice	Restore confidence and assess functional skill
6. Return to play	

Guidelines for Stage Progression: Each stage is 24 hours in duration, no exceptions. If symptoms return during a stage activity, stop all activity and rest for the entire day. The following day, return to the last stage above where symptoms did not occur and progress

accordingly. Each stage should be performed symptom free before progression to the next stage.

**The Athletic Trainer reserves the right to have the final say in all return to play decision. In the event the Athletic Trainer is absent, the licensed healthcare provider's note will stand as is. At no time will a coach make a return to play decision.**

**This concussion management policy is not all-inclusive, and the Athletic Trainer reserves the right to alter the policy at any time as (s)he sees fit to protect the athlete.**

### 4.3.2. Asthma

Asthma is a common respiratory disease that is characterized by intermittent episodes of constriction of the airways (bronchi & bronchioles) in the lungs. This airway constriction is often referred to as bronchial spasm. This bronchial spasm is often accompanied by an increase in bronchial secretions, thus further restricting air flow. When an asthma attack occurs, the athlete may experience coughing, wheezing, and shortness of breath. Asthma attacks may be brought on by a variety of triggers, including dust, pollen, smoke, strong odors, or cold air. Some asthma attacks may be triggered by strenuous exercise. In these cases, the athlete is classified as having exercise induced asthma (IEA).

Student-athletes who have been diagnosed with asthma and require the use of an inhaler should keep their inhaler with them at all practices and games. The location of this inhaler should be shared with the Athletic Trainer to ensure it can be located in emergent situations.

Student-athletes should not share their inhalers with other student-athletes or teammates.

### 4.3.3. Diabetes

Diabetes is a metabolic disease that results due to the absolute or relative lack of insulin.

Diabetes can be divided into two types: Type I (insulin dependent) and Type II (non-insulin dependent). With Type I diabetes, the body is unable to produce insulin, therefore the cells of the body are unable to absorb sugar (glucose) from the blood. This leads to high levels of glucose in the blood. Type I diabetes can be controlled through regular monitoring of blood sugar levels and thru the introduction of insulin. Insulin can either be injected or administered through an insulin pump. Type II diabetes occurs when the body is still able to produce insulin, but either does so in insufficient amounts or produces insulin that does not function properly. This type of diabetes does not require insulin injections and can be controlled through oral medications combined with proper diet and exercise.

Any athlete experiencing the following symptoms should follow up with his/her primary care physician/pediatrician to ensure the athlete is not diabetic. Early detection and treatment of diabetes can decrease the risk of developing complications.

- Frequent urination (dysuria)
- Excessive thirst (polydipsia)
- Excessive hunger (polyphagia)
- Increased fatigue
- Blurry vision
- cuts/bruises that are slow to heal
- Unexplained weight loss
- Tingling, pain or numbness in the hands/feet

Student-athletes with diabetes should regularly monitor their blood glucose levels, especially during and following periods of exercise.

#### 4.3.3.1. Hypoglycemia

The blood sugar of a non-diabetic should fall within the range of 70-140 mg/dL. Hypoglycemia (aka insulin shock) occurs when the body's blood sugar falls below the healthy target range. Hypoglycemia requires immediate action to increase the body's blood sugar back towards its normal range. Signs and symptoms of low blood sugar will have a rapid onset and may include:

- Feeling shaky
- Being nervous or anxious
- Sweating, chills, and clamminess
- Irritability or impatience
- Confusion
- Fast heartbeat
- Feeling lightheaded or dizzy
- Hunger
- Nausea
- Pale skin (pallor)
- Sleepiness
- Feeling weak/decrease in energy
- Blurred/impaired vision
- Tingling or numbness of lips, tongue, or cheeks
- Headaches
- Coordination problems
- Seizure

Treatment of hypoglycemia should follow the "15-15 Rule". Have 15 grams of carbohydrate to raise blood glucose and check it after 15 minutes. If it is still below 70 mg/dL, have another serving. Repeat until blood glucose is back within the normal range.

If hypoglycemia goes untreated, the athlete may fall unconscious. **If a known diabetic athlete is unconscious, call 911 immediately. Do NOT inject insulin (it will lower their blood glucose even more), and do NOT provide food or fluids (choking hazard).**

#### 4.3.3.2. Hyperglycemia

Hyperglycemia occurs when the body's blood glucose is above its normal range. High blood glucose occurs when the body has too little insulin or the body cannot use insulin properly. Signs and symptoms of hyperglycemia include the following:

- High blood glucose
- High levels of sugar in the urine
- Frequent urination
- Increased thirst

When testing, if an athlete's blood glucose is greater than 240 mg/dL, follow up with your doctor in order to check the urine for ketones. If ketones are present, do not exercise. Ketones can cause an even larger increase in blood glucose.

Untreated hyperglycemia may result in ketoacidosis, also known as a diabetic coma. Ketoacidosis occurs when the body does not have enough insulin and is a life-threatening condition. Signs and symptoms of ketoacidosis may include:

- Shortness of breath
- Breath that smells fruity
- Nausea and vomiting
- Very dry mouth

#### 4.3.4. Skin Infections

Skin conditions are a common, yet preventable occurrence among athletes. Perhaps the most serious of these conditions are various skin infections caused by bacteria, fungi, and viruses. Skin infections can be transmitted by both direct (skin-to-skin) and indirect (person to inanimate object to person) contact. Proper infection control can help to minimize the development and spread of skin infections. Besides identification and treatment of infected individuals, preventions can be aided by improving student-athlete hygiene practices and through proper routine cleaning and disinfection of all equipment.

Current knowledge indicates that many fungal and viral infections are easily transmitted by skin-to-skin contact. In most cases, these skin conditions can be covered with a securely attached bandage or non-permeable patch to allow participation. Open wounds and infectious skin conditions that cannot be adequately protected to prevent their exposure to others will be

considered cause for medical disqualification from practice and competition until cleared by a physician.

Any suspicious looking skin lesion will be required to be evaluated by the Athletic Trainer and possibly referred to a physician or dermatologist. **The MHSAA does not allow the covering of a contagious skin condition to in order to compete in wrestling.** If the athlete is not cleared to participate due to a skin lesion, he/she must obtain written clearance from an appropriate physician when no longer contagious in order to return to participation.

#### 4.3.4.1. Reduction of Communicable and Infectious Diseases



### **Official Statement from the National Athletic Trainers' Association on Communicable and Infectious Diseases in Secondary School Sports**

The National Athletic Trainers' Association (NATA) recommends that health care professionals and participants in secondary school athletics take the proper precautions to prevent the spread of communicable and infectious diseases.

Due to the nature of competitive sports at the high school level, there is increased risk for the spread of infectious diseases, such as impetigo, community acquired methicillin-resistant staphylococcus infection (MRSA) and herpes gladiatorum (a form of herpes virus that causes lesions on the head, neck and shoulders). These diseases are spread by skin-to-skin contact and infected equipment shared by athletes, generally causing lesions of the skin.

The following are suggestions from NATA to prevent the spread of infectious and communicable diseases:

- Immediately shower after practice or competition
- Wash all athletic clothing worn during practice or competition daily
- Clean and disinfect gym bags and/or travel bags if the athlete is carrying dirty workout gear home to be washed and then bringing clean gear back to school in the same bag. This problem can also be prevented by using disposable bags for practice laundry.
- Wash athletic gear (such as knee or elbow pads) periodically and hang to dry

- Clean and disinfect protective equipment such as helmets, shoulder pads, catcher's equipment and hockey goalie equipment on a regular basis
- Do not share towels or personal hygiene products with others
- All skin lesions should be covered before practice or competition to prevent risk of infection to the wound and transmission of illness to other participants. Only skin infections that have been properly diagnosed and treated may be covered to allow participation of any kind
- All new skin lesions occurring during practice or competition should be properly diagnosed and treated immediately.
- Playing fields should be inspected regularly for animal droppings that could cause bacterial infections of cuts or abrasions
- Athletic lockers should be sanitized between seasons
- Rather than carpeting, locker or dressing rooms should have tile floors that may be cleaned and sanitized
- Weight room equipment, including benches, bars and handles should be cleaned and sanitized daily

#### 4.4. Blood-Borne Pathogens and Universal Precautions

Universal precautions should be implemented when administering first aid, cardiopulmonary resuscitation or any procedure where the potential for exposure to blood or any body fluid is present. Body fluids include blood, saliva, sweat, vomit, tears, intestinal and urinary tract materials. The purpose of universal precautions is to prevent or minimize exposure to bloodborne pathogens. Universal precautions assumes that all persons are considered potentially infected with a transferable disease. The following universal precautions are followed as closely as possible at Shepherd High School:

1. When treating an injury involving open skin, mucus membranes, blood, or body fluids be sure to wear disposable gloves. Gloves must be changed after contact with each athlete.
2. Wash hands thoroughly with soap and warm water immediately after exposure to blood or body fluids, even if protective gloves have been used.
3. Clean all surfaces that have been exposed to blood or body fluids with a solution consisting of one part chlorine bleach to 10 parts water (1:10) or an approved antimicrobial disinfectant.
4. All existing wounds, abrasions, or cuts that can serve as a source of bleeding, or as a port of entry for bloodborne pathogens, must be covered with an occlusive dressing that can withstand the demands of competition.
5. Dispose of any sharp objects such as needles or scalpel blades in a specially designed sharps container. This container should be red and clearly marked as biohazard material.

6. Dispose of all contaminated materials (bandages, gauze, gloves, etc.) in a specially marked biohazard waste can.
7. During competition and practice, if an athlete is bleeding, he/she must be removed from the practice or game as quickly as possible. Once the athlete has been removed, the bleeding should be stopped and the open wound covered with an occlusive dressing that can withstand the rigors of competition. Athletes with blood on their uniform must be removed from competition until the uniform can be disinfected. Uniforms that have been saturated with blood should be removed and changed before the athlete can return to competition.

## 4.5. Medication Policy

It is generally accepted that minors are not to be provided over-the-counter medications without parental consent. Therefore, the Athletic Trainer, coaches, and other staff will not dispense any medications to student-athletes nor will medications be stored in the Athletic Training Room or coaches office.

## 5. Assessing Body Composition of Wrestlers

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The establishment of a minimum wrestling weight based on 7% body fat for males and 12% for females is required for all senior high schools (NFHS: Sec 5, Art 1, 2 & 3). The MHSAA does not advocate that a wrestler's established minimum weight is the athlete's best weight, but simply the minimum weight at which the athlete will be allowed to compete.

### 5.1. Establishing Minimum Weights

1. Skinfold measurements will be utilized to determine each wrestler's body fat percentage. **This is a REQUIRED step.** Hydro/DXA are only available for an appeal of skinfold. Only measurements taken by MHSAA registered Skinfold Assessors who have successfully completed the MHSAA Skinfold Measurement In-service will be accepted. Schools may access the MHSAA website for a current list of approved assessors. It is the responsibility of the school to contact a Skinfold Assessor from this list and arrange a time to have the wrestling team measured. No senior high wrestler may compete until the athlete has had a minimum weight determined and it appears on the school's Alpha Master. If a junior high school wishes to participate in the minimum weight program it is permitted, but the MHSAA is not prepared to process the data.
2. The lowest weight class a wrestler may compete at will be determined as follows:
  - a. If the predicted weight, at 7% (male) 12% (female) body fat, is exactly that of one of the weight classes, that weight shall be the wrestler's minimum weight class.

- b. If the predicted weight falls between two weight classes they must wrestle at the higher weight class.
    - c. When using digital scales, round up to the nearest 1/10. Balance scales should be rounded up to the nearest 1/4.
  3. Wrestlers below 7% or 12% Body Fat
    - a. Any male wrestler whose body fat percentage at the time of his initial measurement is below 7% must obtain in writing a licensed Physician's (M.D. or D.O.) clearance stating that the athlete is naturally at this sub-7% body fat level.
    - b. In the case of a female wrestler, written Physician's clearance must be obtained for athletes who are sub-12% body fat at her first weigh-in.
    - c. A Physician's clearance is for one season duration and expires April 1 of each year. The sub-7% male or sub-12% female, who receives clearance may not wrestle below their Alpha weight. This form is due to the MHSAA by December 31 and can be found on MHSAA.com. This form must be submitted to the MHSAA and updated in trackwrestling before they may compete.

## 6. Lightning Safety Policy

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### 6.1. Identifying Possible Inclement Weather

Coaches should check a weather report each day before their scheduled practice or event. In this way, the coaching staff will be aware of the possibility of storms forming or moving into the area during the day.

### 6.2. Suspension/Cancellation of Activities

The MHSAA Game suspension policies regarding inclement weather affecting outdoor venues includes the following steps:

1. On threatening days, game management should consult with contest officials about steps to be followed if conditions worsen.
2. When suspending an outdoor contest, officials and game management shall follow these policies:
  - a. When lightning is observed or thunder is heard, the contest must be suspended. The occurrence of lightning or thunder is not subject to interpretation or discussion--*lightning is lightning; thunder is thunder.*
  - b. Severe weather in the form of rain or snow may make the field unplayable.
3. When a contest is suspended, the home administration shall attempt to arrange for the security of all participants.

- a. Contestants and support personnel shall be moved to appropriate indoor facilities.
  - b. When lightning is observed or thunder is heard and the contest is suspended, contestants shall not return to the playing field until lightning has been absent from the local sky and thunder has not been heard for 30 minutes.
  - c. Spectators shall be advised of the action being taken to seek shelter (Some hosts may be able to offer shelter to spectators but are not required to do so.)
4. In considering resumption of competition, the following steps shall be followed:
- a. Delays for contests scheduled prior to 3pm must not exceed three hours. Delays for contests scheduled for 3pm or later must not exceed one and one half hour. Delays on nights not followed by school for all competing teams may be longer by mutual agreement of participating schools. A postponed contest shall be rescheduled on a date/time mutually agreed to by the schools involved.
  - b. A decision to resume the contest within the time frame must be made by the officials who shall consult the home team administration and visiting school administration present at the contest.
  - c. The home school is responsible for facilities and will be given priority consideration in the final decision if there is not consensus among the three parties.
  - d. The final decision shall consider liability and conditions of facilities as well as future schedules, need to play the contest and finally the quality of all other options.

Note: MHSAA tournament policies for MHSAA tournament contests, or more restrictive local policies for regular season contests would supersede these policies and should be shared with the opponents and officials prior to the contest, preferably in writing. Otherwise, and to the extent allowed by the playing rules code, the official(s) shall make the final decision regarding game suspension once the game begins.

All Shepherd High School outdoor athletic practices will follow the thunder and lightning rules outlined by the MHSAA.

### 6.3. Seeking Appropriate Shelter

Seeking shelter in a safe location at the first sign of thunder or lightning activity is highly recommended. By the time the flash-to-bang count approaches 30-seconds; all individuals should already be inside or should immediately seek shelter in a safe location. The primary choice for shelter is any sturdy building normally occupied or frequently used by people. Electric and telephone wiring as well as plumbing pathways aid in grounding buildings, thus making them safer than remaining outdoors during thunderstorms. Open porches or breezeways are not considered appropriate modes of shelter during a thunderstorm.

In the absence of the initial choice for shelter, the secondary choice is a fully enclosed vehicle with a metal roof and the windows closed. It is important not to touch any part of the metal framework of the vehicle while inside it during ongoing thunderstorms. It is important that not only athletes and coaches seek shelter, but spectators and officials as well. Coaches should help to direct spectators and visiting team members to appropriate shelter.

If there is no safe shelter within a reasonable distance, assume a crouched position on the ground with their weight on the balls of their feet in an effort to minimize contact with the ground. Wrap your arms around your knees and lower your head. **DO NOT LIE FLAT!**

Stay away from the tallest trees or lone objects (such as light poles or flag poles), metal objects (metal fences or bleachers), standing pools of water, and open fields. Do not use land-line telephones, except in emergency situations. A cellular telephone or a cordless telephone is a safe alternative to a landline telephone.

#### 6.4. Resumption of Activities Following Suspension Due to Inclement Weather

Once activities have been suspended, teams should wait at least 30 minutes after the last sound of thunder and/or lightning flash before resuming an activity or returning outdoors. The Athletic Trainer will continue to monitor the weather conditions and will decide in conjunction with the Athletic Director, coaches, and officials when it is safe to return to activity.

Per the MHSAA Delays for contests scheduled prior to 3pm must not exceed three hours. Delays for contests scheduled for 3pm or later must not exceed one and one half hour. Delays on nights not followed by school for all competing teams may be longer by mutual agreement of participating schools. A postponed contest shall be rescheduled on a date/time mutually agreed to by the schools involved.

### 7. Prevention of Heat Related Illnesses

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Environmental stress particularly that related to extreme heat & humidity can adversely affect an athlete's performance and in some instances pose a serious health risk. Therefore, it is important to take the proper precautions to help prevent heat related injuries when athletic events take place during days with high ambient temperature and relative humidity. Heat injuries are preventable.

Exercising common sense and adhering to the following recommendations from the MHSAA and NATA can hold heat injuries to a minimum.

## 7.1. Types of Heat Related Illnesses

The signs and symptoms listed below usually do not occur in a stepwise manner and can change rapidly dependent on the person, situation, and activity. All signs and symptoms should be treated as serious and help sought in a timely manner. Categories of heat illness include:

**Exercise-Associated Muscle (Heat) Cramps** – painful muscle cramping of the body usually localized to lower or upper legs, abdomen, or upper extremities. A person suffering from heat cramps will be sweating and thirsty.

**Heat Syncope** – generally referred to as fainting because of exposure to high environmental temperatures, vasodilation, reduced cardiac output, and dehydration. This can occur due to long periods of standing, cessation of activity, or movement from a seated to standing position. Heat syncope usually occurs during the first 5 days of acclimatization. A person who has suffered syncope will usually be dizzy, pale, and have cool, damp skin.

**Exercise (Heat) Exhaustion** – the inability to continue exercise associated with any combination of heavy sweating, dehydration, sodium loss, and energy depletion. A person suffering from heat exhaustion will have an elevated body temperature generally ranging from 36°C (97°F) and 40°C (104°F) but will have cool damp skin and will continue to sweat. They will be weak, dizzy, and may feel as if they will faint. Other symptoms include nausea, headache, chills, hyperventilation, and thirst.

**Exertional Heat Stroke** – *MEDICAL EMERGENCY!* Emergency help is needed immediately! The two main criteria for diagnosing EHS are rectal temperatures >104°F (40°C) immediately post collapse and central nervous system dysfunction (e.g. irrational behavior, irritability, emotional instability, altered consciousness, collapse, coma, dizziness, etc.). A person suffering from heat stroke will be hot to the touch with dry or non-sweating skin. Due to central nervous system changes they may be disoriented, hysterical, delirious, or unconscious. Heart rate and respiration will be elevated with a decrease in blood pressure. Additional symptoms include vomiting, diarrhea, seizures, and coma. **If heat stroke is expected, it is imperative to begin immediate cooling. Remove all excessive equipment/clothing and submerge athlete in cold water.** (See 7.3.4 or *Exertional Heat Illness EAP in the Emergency Action Plan Manual*).

**Exertional Hyponatremia** – A condition of low sodium in the blood. Causes of hyponatremia in athletics may include consumption of too many fluids (see AT for hydration concerns) and use of

diuretics. Signs and symptoms of hyponatremia include nausea and vomiting, swelling of hands and feet, headache, confusion, apathy and lethargy, and altered consciousness. In severe cases, seizures, pulmonary edema, and coma could occur.

## 7.2. Recommendations for the Prevention of Heat Related Illnesses

The Athletic Trainer should have unrestricted access to evaluate and examine any athlete who displays signs or symptoms of heat illness and have the authority to restrict the athlete from participating if heat illness is present. Furthermore, the following general recommendations should be considered when planning a training or competitive program that is likely to take place during hot and humid weather:

### 7.2.1. Fluid and Electrolyte Replacement

The average sweat rate of an athletic individual is about 2-3 liters per hour (50 mL/minute), but the intestines can only absorb water at a rate of 20-30 mL/minute. This means that one cannot hydrate themselves at the rate that they are becoming dehydrated. Start rehydrating early because thirst does not develop until 1-2% of body weight has been dehydrated, by which time performance may have begun to deteriorate. Therefore, it is essential to continually replace fluids lost during exercise by drinking adequate quantities of water or a sports drink during hot weather. Drinks containing caffeine, such as coffee, tea, or soft drinks should be avoided since they act as a diuretic (promotes elimination of fluids through urination). During exercise periods in hot weather, athletes should be given UNLIMITED access to water. Regular breaks should be taken every 20-30 minutes. Athletes should be encouraged to drink fluids before, during, and following exercise in hot/humid conditions to help prevent dehydration and possible heat related injury.

To ensure proper pre-hydration, the athlete should consume approximately 17-20 oz of water or a sports drink about 2-3 hours prior to exercise and another 10-17 oz of water/sports drink 15-30 minutes prior.

Following exercise, the individual should attempt to correct any fluid loss which may have occurred during the exercise activity. The easiest method of determining proper hydration status is through the examination of urine color. The urine of a properly hydrated athlete should be clear to light yellow in color. Darker colored urine is a good indication that the athlete needs to consume more fluids. Weight loss can also be used to determine the extent of fluids needed to correct fluid loss. Replace every pound of body weight lost during practice/event with 16-24 oz. of fluids. It is best to replace fluids lost within 2-3 hours of exercise. Within 45 minutes after

session, athletes should consume 45-50 grams of carbs and 13-15 grams of protein. Good post-practice food choices include fruit, raisins, pretzels, yogurt, power bar, bagel, etc.

## 7.2.2. Gradual Acclimatization

This is perhaps the single most effective method of preventing heat related injuries. Acclimatization should allow students-athletes to gradually become accustomed to exercising in hot and humid conditions. Coaches have the responsibility of designing practice schedules so that student-athletes will be gradually exposed to hot and/or humid conditions over a 10-14 day period. Well-acclimatized athletes should train for 1-2 hours in the same heat conditions that will be present for their event.

### 7.2.2.1. Recommendations for the Heat Acclimatization Period

The MHSAA recognizes that there are unique and variable climates in Michigan and that there is no “one-size-fits-all” optimal acclimatization plan. Acclimatization should occur gradually over 10-14 days by progressively increasing the intensity and duration of work in the heat with a combination of strenuous interval training and continuous exercise.

## 7.2.3. Identifying Susceptible Individuals

It is important to identify individuals who are prone to heat related injuries so that they can be more closely monitored during activity. An accurate medical history can help the Athletic Trainer and coaches to better identify susceptible individuals. Without proper precaution and care, any individual is susceptible to heat illness; however, individuals with a higher susceptibility to heat illnesses include older athletes, overweight athletes, unacclimatized athletes, individuals with a history of heat illness, individuals with a fever, and individuals with chronic illnesses.

## 7.2.4. Temperature and Humidity Readings

MHSAA Model Policy for Managing Heat & Humidity

1. Thirty minutes prior to the start of an activity, and again 60 minutes after the start of that activity, take temperature and humidity readings at the site of the activity. Using a digital sling psychrometer is recommended. Record the readings in writing and maintain the information in files of school administration. Each school is to designate whose duties these are: generally the athletic director, head coach or certified athletic trainer.
2. Factor the temperature and humidity into the Heat Index Calculator and Chart to determine the Heat Index. If a digital sling psychrometer is being used, the calculation is automatic.
3. **If the Heat Index is below 95 degrees:**
  - All Sports

- Provide ample amounts of water. This means that water should always be available and athletes should be able to take in as much water as they desire.
  - Optional water breaks every 30 minutes for 10 minutes in duration. o Ice-down towels for cooling.
  - Watch/monitor athletes carefully for necessary action.
4. If the Heat Index is 95 to 99 degrees:
- All sports
    - Provide ample amounts of water. This means that water should always be available and athletes should be able to take in as much water as they desire.
    - Optional water breaks every 30 minutes for 10 minutes in duration.
    - Ice-down towels for cooling.
    - Watch/monitor athletes carefully for necessary action.
  - Contact sports and activities with additional equipment:
    - Provide ample amounts of water. This means that water should always be available and athletes should be able to take in as much water as they desire.
    - Optional water breaks every 30 minutes for 10 minutes in duration. o Ice-down towels for cooling.
    - Watch/monitor athletes carefully for necessary action.
    - Helmets and other possible equipment removed while not involved in contact.
  - Reduce time of outside activity. Consider postponing practice to later in the day.
  - Recheck temperature and humidity every 30 minutes to monitor for increased Heat Index.
5. If the Heat Index is 99 to 104 degrees:
- All Sports
    - Provide ample amounts of water. This means that water should always be available and athletes should be able to take in as much water as they desire.
    - Mandatory water breaks every 30 minutes for 10 minutes in duration. o Ice-down towels for cooling.
    - Watch/monitor athletes carefully for necessary action.
    - Alter uniform by removing items if possible. o Allow for changes to dry t-shirts and shorts.
    - Reduce time of outside activity as well as indoor activity if air conditioning is unavailable.

- Postpone practice to later in the day. Contact sports and activities with additional equipment:
  - Helmets and other possible equipment removed if not involved in contact or necessary for safety. If necessary for safety, suspend activity.
  - Recheck temperature and humidity every 30 minutes to monitor for increased Heat Index.
6. If the Heat Index is above 104 degrees:
- All sports
    - Stop all outside activity in practice and/or play, and stop all inside activity if air conditioning is unavailable.

Note: When the temperature is below 80 degrees, there is no combination of heat and humidity that will result in need to curtail activity.

### 7.2.5. Heat Index Calculation and Chart

## 7.3. Recognition and Treatment of Heat Related Illnesses

These guidelines are derived from the *National Athletic Trainers' Association Position Statement: Exertional Heat Illnesses*.

### 7.3.1. Exercise-Associated Muscle (Heat) Cramps

- Signs and symptoms: dehydration, thirst, sweating, transient muscle cramps, and fatigue
- To relieve muscle spasms, the athlete should stop activity, replace lost fluids with sodium-containing fluids, and begin mild stretching with massage of the muscle spasm.
- Fluid absorption is enhanced with sports drinks that contain sodium. A high-sodium sports product may be added to the rehydration beverage to prevent or relieve cramping in athletes who lose large amounts of sodium in their sweat.

### 7.3.2. Heat Syncope

- If an athlete experiences a brief episode of fainting associated with dizziness, tunnel vision, pale or sweaty skin, and a decreased pulse rate but has a normal rectal temperature (for exercise, 36.8°C to 40.8°C [97.8°F to 104.8°F]), then heat syncope is most likely the cause.
- Move the athlete to a shaded area, monitor vital signs, elevate the legs above the level of the head, and rehydrate.

### 7.3.3. Exercise (Heat) Exhaustion

- Cognitive changes are usually minimal, but assess central nervous system function for bizarre behavior, hallucinations, altered mental status, confusion, disorientation, or coma to rule out more serious conditions.
- If feasible, measure body-core temperature (rectal temperature) and assess cognitive function and vital signs. Rectal temperature is the most accurate method possible in the field to monitor body-core temperature. The AT should not rely on the oral, tympanic, or axillary temperature for athletes because these are inaccurate and ineffective measures of body-core temperature during and after exercise.
- If the athlete's temperature is elevated, remove his or her excess clothing to increase the evaporative surface and to facilitate cooling.
- Cool the athlete with fans, ice towels, or ice bags because these may help the athlete with a temperature of more than 38.88°C (102.8°F) to feel better faster.
- Remove the athlete to a cool or shaded environment if possible.
- Start fluid replacement.
- Transfer care to a physician if intravenous fluids are needed or if recovery is not rapid and uneventful.

#### 7.3.4. Exertional Heat Stroke

- Measure the rectal temperature if feasible to differentiate between heat exhaustion and heat stroke. With heat stroke, rectal temperature is elevated (generally higher than 40°C [104°F]). **Rectal thermometry will not be used without prior parental consent.**
- Assess cognitive function, which is markedly altered in exertional heat stroke.
- Lower the body-core temperature as quickly as possible. The fastest way to decrease body temperature is to remove excess clothing and equipment and immerse the body (trunk and extremities) into tub of cold water. Aggressive cooling is the most critical factor in the treatment of exertional heat stroke. Circulation of the tub water may enhance cooling.
- Monitor the temperature during the cooling therapy and recovery (every 5 to 10 minutes). Once the athlete's rectal temperature reaches 102°F, he or she should be removed from the tub to avoid overcooling. If rectal thermometry is not being used to continuously monitor the athlete's temperature, the athlete will be submerged for 15 minutes and then removed from the tub.
- If a physician is present to manage the athlete's medical care on site, then initial transportation to a medical facility may not be necessary so immersion can continue uninterrupted. If a physician is not present, aggressive first-aid cooling should be initiated on site and continued during emergency medical system transport and at the hospital until the athlete's temperature has returned to normal (normothermic).
- Activate the emergency medical system.
- Monitor the athlete's vital signs and other signs and symptoms of heat stroke.
- During transport and when immersion is not feasible, other methods can be used to reduce body temperature: removing the clothing; sponging down the athlete with cool water and applying cold towels; applying ice bags to as much of the body as possible, especially the major vessels in the armpit, groin, and neck; providing shade; and fanning the body with air.
- In addition to cooling therapies, first-aid emergency procedures for heat stroke may include airway management.
- Monitor for organ-system complications for at least 24 hours.

#### 7.3.5. Exercise Hyponatremia

- Attempt to differentiate between hyponatremia and heat exhaustion. Hyponatremia is characterized by increasing headache, significant mental compromise, altered consciousness, seizures, lethargy, and swelling in the extremities. The athlete may be dehydrated, normally hydrated, or overhydrated. The body's temperature will not be as elevated as with hyperthermia (rectal temperatures less than 104°F).

- If hyponatremia is suspected, immediate transfer to an emergency medical center via the emergency medical system is indicated. An intravenous line should be placed to administer medication as needed to increase sodium levels, induce diuresis, and control seizures.
- An athlete with suspected hyponatremia should not be administered fluids until a physician is consulted.

### 7.3.6. Return to Play

In cases of exercise-associated muscle (heat) cramps or heat syncope, the AT should discuss the athlete's case with the supervising physician. The cases of athletes with heat exhaustion who were not transferred to the physician's care should also be discussed with the physician. After exertional heat stroke or exertional hyponatremia, the athlete must be cleared by a physician before returning to athletic participation. The return to full activity should be gradual and monitored.