

Ohio Valley University Emergency Action Plan

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Emergency Contacts

Emergency Management Services (EMS): 911

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The purpose of the Emergency Action Plan (EAP) is to provide a clear and concise plan of action in response to any emergency situations that may arise at the different athletic venues at Ohio Valley University. That being said this document will outline the necessary steps and procedures should an emergency situation arise during an athletic practice or competition at the following venues: Snyder Activity Center (SAC), OVU Soccer/Softball Field, Jackson Park Softball Field, Parkersburg High School, and City Park Baseball Field. Some examples of emergency situations include but are not limited to: fractures, heat stroke/syncope, seizures, myocardial infarction, cervical spine injury, and other severe trauma.

EMERGENCY PLAN

I. Emergency Protocol

The main concern of emergency aid is to maintain cardiovascular function, and indirectly, central nervous system function, because failure of any of these systems may lead to death. The key to emergency aid in the sports setting is the initial evaluation of the injured athlete. Time is critical, so this evaluation must be done rapidly and accurately so that proper aid can be rendered without delay.

Personnel

In the event of an emergency, the following individuals will be responsible for the initial evaluation and treatment of the injured athlete:

1. The team physician or supervising, on-site physician.
2. The head athletic trainer
3. Assistant athletic trainers
4. Head coach

Communication with EMS

An Athletic Trainer will initiate activation of Emergency Medical Service (EMS) personnel by directing one individual (staff athletic trainer, athletic training student, coach) to dial 911. All athletic training staff and students, as well as coaching staff and graduate assistants, should know the location of a phone nearest to the practice and game area, and the procedures for using walkie-talkies.

Location of phone and activating EMS: cell phones

The following information will be provided to the dispatcher:

- a. Your name and title.
- b. The type of emergency and/or nature of the injury(s).
- c. Present condition of the athlete.
- d. Location of the injured athlete (specific, with a landmark, i.e. front campus, basketball court, etc.)
- e. Phone number where you are calling from.
- f. Where you or someone will meet the ambulance
- g. Hang-up only after the dispatcher has hung-up.

Communication with Parents/Guardians

After a major injury or emergency situation has occurred and the athlete is stable the parents or guardians may need to be notified about the status of the athlete, appropriate follow-up care, and any physician referrals. This will be accomplished by phoning the number that the athlete indicated as their emergency contact or by directly speaking to the parent/guardian if they are present at the game/practice.

Documentation:

In all emergency situations, the Athletic Trainer on site during time of emergency will be responsible for providing a thorough account of the mechanism of the athlete's injury, the initial signs and symptoms, any care given, the time elapsed, and any pertinent medical information concerning the athlete, to the EMS personnel. All of this information should be included in a written athletic injury report. All written reports will be kept on file in the Athletic Training Room (ATR).

Emergency equipment

The following emergency equipment will be available at all athletic team practices and games, unless otherwise noted:

Medical kit

-On site with ATC during practices and games, or located in ATR

Vacuum splints

-ATR or on the sidelines during games

Backboard (EMS responsibility) (be sure to inform the EMS that it is needed)

C-collar- inform EMS that one is needed

Knee immobilizer- ATR

Automated External Defibrillator

-located in the ATR, weight room, or on the sidelines during games

CPR

All athletic training staff and students are required to obtain certification in cardiopulmonary resuscitation, and to maintain current certification (re-certification every two years).

Additionally, the athletic training staff will maintain current certification in the use of the external automated defibrillator. At all times (other than home athletic events) the AED and Emergency Kit will be stored in the athletic training room and weight room.

In the event that an athlete collapses and is unresponsive the certified athletic trainers and other qualified on-site personnel need to provide CPR and basic life support until EMS personnel arrive on the scene.

The following steps outline the updated American Heart Association guidelines on CPR and advanced life support for health care providers.

Single Person CPR

1. In the event that only one ATC is present and an athlete collapses and is unresponsive the ATC will direct one of the coaches to call 911 and another to retrieve the closest AED.
2. If no pulse is detected then the ATC will perform cycles of 30 chest compressions. Compressions will be hard and fast at a rate of 100 per minute.
3. Now the ATC will open the athlete's airway using the head tilt chin lift. If the ATC suspects any cervical spine injuries he/she will use the jaw thrust method to open the airway. The ATC will then check for adequate breathing by looking, listening, and feeling for any breathing.
4. If no breathing is detected then 2 rescue breaths will be administered by the ATC causing the chest to visibly rise.
5. Once the AED arrives, it is attached, and has determined that there is a shockable rhythm the ATC will initiate a shock from the AED after warning everyone to keep clear. Resume CPR for 5 more cycles (starting with compressions) before checking for a shockable rhythm again.
6. Once EMS arrives, the ATC will follow the instructions given by EMS team and follow up with the athlete accordingly.

Two Person CPR

1. When an athlete collapses and is unresponsive and 2 ATC's are present the previous steps outlined in the above single person will be used but responsibilities for CPR will be divided between the two ATC's.
2. Each ATC will be designated to perform either chest compressions at the victim's side or to maintain an open airway and give breaths at the victim's head.
3. The responsibilities of the ATC giving compressions at the victim's side are to perform quality chest compressions at a rate of 100 per minute and to count the compressions out loud. In addition, once the AED arrives this ATC will attach the electrodes and initiate a shock if appropriate.
4. The responsibilities of the ATC at the athlete's head are to maintain an open airway and provide 2 breaths after a set of 30 compressions.
5. ATC's should switch duties every 5 cycles or 2 minutes to prevent fatigue.
6. Once EMS personnel arrive on scene the ATC's will follow their instructions and perform appropriate follow up for the athlete.

PRONE ATHLETE – NOT BREATHING

- a. Determine unconsciousness; check compressions, airway, breathing (CAB); determine lack of breathing; the first person at the scene is in charge of stabilizing the head in a cross-hand technique; and gives orders to move the athlete.
- b. Log roll immediately with head in neutral position (maintain alignment with spine with traction)
- c. Football: cut mask, swing mask upward to expose athlete's face; HELMET STAYS ON! Also keep the chin strap on the helmet in place.
- d. Repeat CAB's check; activate EMS; begin CPR; ATC at head maintains traction.
- e. Arrange for transport.

PRONE ATHLETE – UNCONSCIOUS, BREATHING

- a. Determine unconsciousness; check CAB's; determine presence of breathing & pulse
- b. Do not allow athlete to be moved;
- c. Activate EMS;
- d. Closely monitor athlete's vital signs;
- e. If athlete regains consciousness, complete neurological evaluation before allowing movement.
- f. Remove from all activity until evaluated by an MD.

PRONE ATHLETE – CONSCIOUS

- a. Determine consciousness – “Are you o.k.?”
- b. Do not allow athlete to be moved; perform primary survey.
- c. Keep athlete calm; provide reassurance.
- d. Ask for chief complaint.
- e. If spinal cord injury is suspected:
 - check movement of fingers and toes
 - check sensation in extremities
 - ask about neck or back pain
 - ask about numbness or tingling in extremities;
- f. If suspicious, activate EMS; move only with c-collar & backboard.

Suspected Spinal injury

1. do not move athlete or let them move
2. 1st person trained at the c-spine needs to maintain c-spine
3. if conscious and breathing wait for EMS and have a second trained individual perform a secondary survey
4. if unconscious and facedown, log roll onto back and perform rescue breathing. Initiate CPR if needed.
5. monitor CAB's

Seizures

1. do not attempt to restrain the athlete
2. loosen restrictive clothing and remove any objects that the athlete could potentially run into
3. attempt to cushion the athlete's head with a pillow, towel, or other soft object
4. once active seizing stops place athlete on side if no spinal injury is suspected
5. expect the athlete to have an altered mental status and be prepared to provide rescue breathing
6. monitor CAB's until EMS arrives

Severe allergic reactions

1. Signs and symptoms may include hives all over the body, tightness in the chest and/or throat, wheezing with breathing, dizziness or lightheadedness, increased heart rate, and anxiety.
2. If the above symptoms are present and the athlete has an Epi-pen or bee sting kit assist the athlete in administration:
 1. wipe skin with alcohol pad
 2. remove cap from auto injector
 3. place the tip of the auto-injector against the outside of the thigh and press firmly until you see the medication has been injected (you will hear a spring release after which you hold for 10 seconds)
3. Continue to monitor vitals until EMS arrives.

Obvious or suspected fracture

1. Do not move or allow the athlete to move.
2. Splint joint above and below a suspected long bone fracture.
3. Splint the long bone above and below a suspected fracture at the joint.
4. For open fractures apply a clean dressing to the fracture site and control the bleeding.
5. Check pulse, motor, and sensory function below the suspected fracture site.
6. Keep the athlete calm and monitor for signs and symptoms or shock while awaiting EMS arrival.

Severe Bleeding

1. Apply direct pressure to the wound with a gloved hand and gauze.
2. If bleeding continues elevate the wound above the level of the heart while continuing to apply direct pressure unless fracture is suspected.
3. If bleeding cont apply pressure to the appropriate pressure point (brachial artery for UE and femoral artery for LE).
4. Monitor CAB's and look for sign and symptoms of shock while awaiting EMS

Heat Illnesses

The athlete should lose no more than 2-3% of body weight during each practice; after practice the individual should replenish the fluids and return to normal body weight; a heavier individual will lose more weight. Any athlete with exhibiting the ss, sn of heat illness should be immediately removed from play. Such ss, sn include: headache, nausea, chills undue fatigue, dizziness, lightheadedness, disorientation and pale or clammy skin. The athlete should be removed to a cool area, given ample cool water, and monitored closely. All athletes should monitor their weight closely in the hot and humid weather months. Weight charts are mandatory for preseason football. Athletes who have lost 3% or more of their body weight over 24 or more hours should be held from practice until their weight returns to normal and they are adequately rested and hydrated. Any athlete who displays the ss, sn of heat stroke, such as hot, dry skin; disorientation; loss of consciousness; seizures; temperature of over 103 degrees; decreasing level of consciousness; decreasing respirations or a low BP with a wide pulse pressure should be assumed to have heat stroke. Heat stroke is treated as a medical emergency. Following the primary survey, the athlete should be covered with cool towels and ice packs, vitals should be monitored, loss of consciousness should be expected and immediate transportation to the ER should be arranged for. Prevention of heat illnesses should be stressed by the athletic training staff.

Dehydration- give individual plenty of fluids; if athlete lost too much weight have the athlete sit out and drink fluids; the athlete may not return to play until their weight returns.

Heat cramps - intense pain and persistent muscle contractions
- treatment- rehydrate, light stretching and massage.
- ice

Heat syncope- dizziness/fainting
- treatment- perform primary and secondary survey if patient faints; monitor vitals, get in cool area once the athlete comes to and there is no suspicion of spinal injury; rehydrate

Heat exhaustion- ss,sn- temperature less than 104° F, increased blood pressure, profuse sweating, rapid recovery with treatment
Treatment- remove from play and place in a cool area, remove excess clothing, have athlete lay with legs propped above heart level, rehydrate with fluids if athlete can, monitor vitals

Heat stroke- ss,sn- altered consciousness, temperature 104° F or higher, dry skin, increased heart rate, decreased blood pressure, increased respiratory rate
treatment- aggressive and immediate whole body cooling, cold water immersion then transport, remove clothing, check CAB's, monitor vitals call 911

Exertional hyponatremia- an athlete consumes more fluids than necessary and/or sodium lost in sweat is not adequately replaced fluid intake should not exceed fluid lost and sodium is adequately replaced
treatment- if sodium levels can not be assessed do not hydrate and transport or call 911

Scenarios

Lone ATC

When only one ATC is present the ATC needs to be sure that the coaches and other staff understand the procedure to be used if EMS should need to be contacted. The ATC needs to try his/her best to make sure that all athletes are properly diagnosed, treated, and if needed follow-up and referrals made. In the event that a cervical spine injury occurs the lone ATC needs to stabilize the athlete's cervical spine and give orders to coaches and other rescuers concerning emergency care, activation of EMS, and etc.

Multiple ATCs

In the event that one of the situations mentioned in this plan should the proper steps outlined with the injury need to be followed by ATC. That being said, the proper steps to resolving an injury can be modified when two or more ATC's are present in order to speed along the treatment for an injured athlete by completing multiple tasks at one time.

Multiple Injuries

When multiple injuries occur and there is only one ATC the ATC will perform triage according to his/her best judgment based on the athletes' symptoms. The ATC will then provide the appropriate treatment and if necessary for any injuries have a coach activate EMS. The lone ATC must document and justify their actions for injury treatment order. In the event that there are multiple injuries and two or more ATCs present the same triage steps will be followed and athletes will be treated on the basis of seriousness of their condition. Recognition and treatment will occur faster because there are two ATCs. Athletic training students may also be utilized in the injury recognition, treatment, and triage process if found to be competent in the skills needed to recognize and treat the particular injuries.

Vital Signs

In the event of an emergency and in cases of injury to the head, neck, abdomen or chest, heat illness, severe bleeding, acute abdomen and severe fractures, it is critical that the athletic trainer (or coach in the absence of the athletic training staff) monitor and record the athlete's vitals.

Pulse

Best found at the carotid artery

Normal: adults = 60-80 beats per minute

Measure for 30 seconds then multiply by 2

Respirations

Normal: adults = 12-20 breaths per minute

Measure for 1 full minute

Blood Pressure

Normal systolic (college athlete) range = 115-120 mmHg

Normal diastolic range = 75-80 mmHg

Females usually have 8-10 mmHg lower BP

Note: pulse, respiratory rate and BP values may run lower in trained athletes

Temperature:

Normal (oral, adult) = 98.6° F

Skin

In the light pigmented athlete, three colors are commonly identified in medical emergencies: red, white and blue. Red skin color may indicate heatstroke or high blood pressure. A pale, ashen or white color skin could mean insufficient circulation, shock, fright, hemorrhage, heat exhaustion or insulin shock. Skin that is of bluish color usually means that circulating blood is poorly oxygenated. In the dark pigmented athlete, check the coloration of the nail beds and inside the lips, mouth and tongue. When a dark skinned person goes into shock the skin around the mouth and nose will often have a grayish cast, whereas the tongue, inside of the mouth, the lips and nail beds will have a bluish cast.

Pupils

Check for **PERRLA** with a penlight or other light source.

Pupils are Equal Round Reactive to Light and Accommodating

LOC

Level or state of consciousness. Normally, the athlete is alert, aware of his or her environment and responds quickly to verbal commands.

Movement

The inability to move a body part may indicate a serious central or peripheral nervous system injury that has involved the motor system.

Abnormal Nerve Response

Numbness or tingling in a limb with or without movement may indicate nerve or cold damage.

Specific Injury or Medical Conditions

Dental Injury

All dental injuries should be referred as soon as possible. Avulsed or subluxed teeth should be re-implanted or realigned as soon as possible (< 30 min following injury). Avulsed teeth that cannot be re-implanted should be placed in a "Save-a-tooth" container. An athlete who suffers a fractured tooth may continue to play and then see a dentist soon after (< 24 hours later).

Mandible Injury

Any athlete who suffers a possible fracture of the mandible should be immediately immobilized, have ice applied directly to the injured area and be immediately referred to the ER or team physician. The ss, sn of a mandible fracture include: deformity, loss of normal occlusion of the teeth, pain when biting down, bleeding around the teeth and lower lip anesthesia.

Eye injuries

All eye injuries should be evaluated immediately. Eye injuries where there appears to be retinal detachment, perforation of the globe, foreign object embedded in the cornea, blood in the anterior chamber, decreased vision, loss of the visual field, poor pupillary adaptation, double vision, laceration or impaired lid function, should be immediately referred to the ER. The eye should be carefully patched and covered with a shield, and the athlete should be transported in the recumbent position if possible. In the case of a surrounding soft tissue injury, an ice pack may be applied. Be sure to have a layer between the ice and the eye

Upper Respiratory Infection

Any athlete experiencing a persistent fever, an inflamed throat, swollen tonsils, chills, myalgias, nasal congestion, severe sore throat, fatigue or cough should be referred to the physician. Treatment generally involves rest and fluids. All sickness treated in the Athletic Training Room must be recorded on an injury report.

Allergic Rhinitis

Athletes suffering from allergic rhinitis generally present with the following ss, sn: itching of the eyes, nose and throat; watering of the eyes; sneezing and a clear, watery nasal discharge; a sinus-type headache, emotional irritability, difficulty in sleeping, red and swollen eyes and nasal mucous membranes and a wheezing cough. The athlete should be referred to physician. Athletes who are taking antihistamines should be warned about the importance of increased fluid intake and the risks associated with hot weather exercise.

G.I. Upset

Athletes with gastrointestinal symptoms (nausea, diarrhea, vomiting, dyspepsia) should be placed on a diet of bland food and clear liquids for 24 hours. If the symptoms still persist after this time period then the athlete should be referred to the physician. Athletes with acute abdominal pain with muscle guarding and rebound tenderness should be immediately referred to the ER or team physician.

Genitourinary Urinary Conditions

Athletes experiencing genitourinary symptoms, such as frequency of difficulty with or painful urination, tenderness over the costovertebral angle or flank, fever, and/or discharge, should be advised to increase their fluid intake and be seen physician as soon as possible.

Testicular Trauma

Any male athlete who receives a blow to the groin region and who complains of persistent pain and swelling of the scrotum should be examined immediately for the possibility of spermatic cord torsion or traumatic hydrocele of the tunica vaginalis. Any athlete suspected of having more than a transient spasm of the scrotum should be immediately referred to the ER or team physician.

Acute Upper Extremity Injuries

All minor (strains, sprains, contusions) injuries to the upper extremity should be properly evaluated and treated with ice, compression, elevation and immobilization with a sling if necessary. The athlete should be advised to continue ice treatments and be scheduled for a follow-up appointment (within 24 hrs.) in the Athletic Training Room. All hand and wrist injuries should be immobilized in the position of function. Finger injuries, including possible fractures should be splinted according to the following chart:

Injury	Splinting Position
Collateral ligament sprain	30° flexion
PIP and DIP dislocations (post reduction)	30° flexion
Mallet finger	slight DIP hyperextension
Phalangeal fracture	straight splint
MCP fracture	30° flexion

Any suspected rupture of the flexor digitorum profundus, fracture and/or dislocation should be immediately referred to the team physician. All long bone fractures and dislocations of the upper extremity should be treated as a medical emergency and referred immediately to the ER.

Acute Lower Extremity Injuries

All minor (strains, sprains and contusions) injuries to the lower extremity should be properly evaluated and treated with ice, compression, elevation and immobilization when necessary. Whenever compression is applied, the athlete should be advised of the ss, sn indicating possible impairment of circulation or a compartment syndrome.

All knee and ankle injuries presenting with ligamentous instability should be placed in an immobilizer and the athlete should be fitted with crutches and advised on a non-weight bearing gait. In cases of a suspected third degree sprain, or severe pain, disability or suspected hemiarthrosis, the athlete should be referred to the ER or an orthopedic surgeon. All first and second degree sprains of the knee and ankle should be referred to the team physician for consideration of an x-ray to rule-out fracture. All long bone fractures and dislocations of the lower extremity should be treated as a medical emergency and referred immediately to the ER. All athletes who suffer any degree of injury to the lower extremity should be advised to use crutches and a non- or partial weight bearing gait until they can walk without a limp. All injured athletes should be advised to schedule a follow-up appointment in the Athletic Training Room within 24 hrs of their injury.

Spinal Injuries

Any athlete who suffers a spinal injury and exhibits the following signs, should be treated as a medical emergency, placed in a cervical collar and on a backboard and transported via ambulance to the ER: tingling, paresthesia, or numbness in the extremities; deformity of the spine; inability to move the extremities; pain in spinal region; point tenderness along the spine; history of a "crack" "snap" or "pop" in the spinal region at the time of the injury; weakness of grip; loss of consciousness due to a head injury and associated spinal trauma.

Head Injury and Concussion

Any student-athlete who exhibits signs, symptoms or a change in behavior consistent with a concussion shall be removed from practice or competition and evaluated by the athletics healthcare provider with experience in the evaluation and management of concussion. Student-athletes diagnosed with a concussion shall not return to activity for the remainder of that day. Medical clearance shall be determined by the team physician (Leah Hopkins) or their designee. If the team physician is unavailable the athlete will be instructed to go to med express or an emergency room. Any head injury resulting in loss of consciousness or suspected skull fracture should be considered a medical emergency. Following the primary survey and vitals check the athlete should be placed in a cervical collar and on a backboard and transported to the ER via ambulance. Although there are different severities of a concussion, each will be treated with equal care.

The OVU team physician allows the athletic trainer to clear a concussion whose symptoms resolve in 15 minutes or less to return to practice the following day if asymptomatic. The athlete must first pass a cognitive and a functional test and remain asymptomatic. Any athlete whose symptoms last more than 15 minutes must sit out until return to play protocol can be followed without symptoms of a concussion.

Immediate signs of a concussion, occurring within seconds to minutes, include the following:

- impaired attention-vacant stare, delayed responses, inability to focus
- slurred or incoherent speech
- gross incoordination
- disorientation
- emotional reaction out of proportion
- memory deficits
- any loss of consciousness

Later signs of concussions, occurring within hours to days may include the following:

- persistent headache
- dizziness/vertigo
- poor attention and concentration
- memory dysfunction
- nausea or vomiting
- fatigue easily
- irritability
- intolerance of bright lights
- intolerance of loud noises
- anxiety and or depression
- sleep disturbances

After a concussion, a physician or their designee must give clearance to practice or compete. When determining the safe return of an athlete with a head/brain injury it is essential to include all members of the sports medicine team; consisting of the athlete, parents, physician, athletic trainer, coach, and other medical specialist.

Any athlete who has suffered a previous concussion within the same year is subject to sitting out longer and may be advised by the team physician or referred to a neurosurgeon to terminate his/her season. In addition, the athletic trainer should discuss with the athlete and his or her parents the significance of the injury and the importance of follow-up care.

Return to play protocol

According to the Zurich guidelines, any athlete experiencing symptoms of a concussion must go to the doctor for diagnosis and a return to play date. Most athletes recover within several days from a concussion, but to ensure a gradual and safe return to play there is a progression of activities. The first step is rest both mentally and physically. Each level should take 24 hours with the athlete asymptomatic before moving to the next level in the progression. If any symptoms occur during the progression, the athlete should drop back to the previous level and try to complete after a 24 hour rest period. The progression levels are as follows:

- no activity with complete physical and cognitive rest
- light aerobic exercise
- sport specific exercise
- non-contact training drills (more intense sport drills with no contact)
- full contact practice (following medical clearance)
- return to play

The progression should take one week from asymmetric rest to full competition. After the athlete is cleared by a doctor and is able to do the progression exercises, they may return to full go. If a doctor clears the athlete, but the symptoms return, the athletic trainer can still hold the athlete from participation. Every situation will be treated individually, as no two brain injuries are the same.

Traumatic Blows to the Abdomen or Chest

Any athlete who sustains a blow to the chest or abdominal region should be immediately evaluated by the team physician or his or her absence the athletic trainer (See Emergency Protocols).

Athletes who display any of the following symptoms and signs should be immediately referred to the ER: abdominal rigidity, rebound tenderness of the abdomen, nausea, vomiting, decreased level of consciousness, increased pulse, decreased BP, lethargy, behavioral change, anxiousness, severe abdominal or back pain, pain radiating to the left shoulder, difficulty in breathing, cyanosis of the lips, nail beds or face, coughing up of blood or "coffee ground-like" substance, flail chest, deformity of the chest wall or severe chest pain. The athletic trainer should discuss with the athlete and his or her parents the significance of the injury and the importance of follow-up care.

Traumatic Lacerations and Skin Wounds

All wound care requires the athletic trainer to first control the bleeding by means of direct pressure, elevation and indirect pressure if necessary. Once the bleeding has been controlled, the wound should be irrigated with water or normal saline solution, cleaned with anti-bacterial soap and water, irrigated again and then dressed with antibiotic ointment (Neosporin, Polysporin, generic triple antibiotic ointment, etc.) if needed. All lacerations or wounds which are approximately 1/4" wide and 1/4" deep or more should be closed with steri-strips or proxi-strips and then referred to the team physician or ER for consideration for stitches (within 4 hrs of the injury, if possible). All head and facial wounds should be seen by the team physician or ER as soon as possible.

In handling any wound, Universal Precautions should be taken. (see Section III).

Athletes sustaining lacerations, punctures or wounds caused by contaminated objects should be considered for a tetanus shot. The team physician or ER staff should be consulted on this matter. Hydrocortisone cream (.5%) may be used to control itching lesions. In fungal skin infections, Micatin, Lotrimin or Tinactin cream should be recommended and the athlete should be instructed to use the medication BID for at least two weeks, even after all symptoms disappear. If the athlete's fungal infection spreads or worsens he/she should be referred to the physician.

Allergic Reactions

Bee stings: Ask the athlete if he or she has an allergy; remove the stinger if possible and apply ice to the area; watch for signs of severe allergic reaction: swelling of the face, mouth or neck; difficulty in breathing or chest tightness; dizziness or lightheadedness; hives and severe itching; decreased BP. In the event of a severe allergic reaction (difficulty in breathing, rapid swelling of the face or mouth) the athletic trainer should administer a bee sting kit (adrenaline) as directed by the package instructions, and transport the athlete immediately to the ER.

Medications: In the event of the athlete taking medication, the sudden appearance of hives or a general body rash, may indicate a drug reaction. Instruct the athlete to discontinue taking the drug immediately and refer him or her to the ER. If the athlete's symptoms are more severe (difficulty in breathing, wheezing, facial edema, etc.) transport immediate to the ER.

Asthma

Asthma should be well controlled before participation in athletics. If an athlete's asthma is exacerbated by exercise the athlete should use medications as prescribed by their physician. Athletes who use inhalers during exercise to reduce asthma symptoms should be instructed on proper administration technique: after shaking the inhaler vigorously, the athlete should exhale fully then while pinching off his or her nose, inhale 2 full puffs from the inhaler; each inhaled puff should be held for 10 seconds to allow the medication to saturate the tissues. Stress to the athlete that the inhaler should not be overused nor used as a crutch; athletes with asthma should be encouraged to drink increased amounts of water before, during and after exercise. If wheezing persists or worsens and the athlete suffers air hunger with coughing and bronchospasm, transport the athlete to the ER for further evaluation.

Diabetes (Type I, Insulin Dependent)

Diabetes should be well controlled with insulin and diet before the athlete participates in his or her sport. At the beginning of the season (especially preseason) with intense exercise, many diabetics experience transient episodes of hypoglycemia, characterized by dizziness, fatigue, weakness, sweating and sometimes progressing to disorientation and stupor. If the athlete has taken his or her scheduled dose of insulin (question carefully about this) hypoglycemia can be treated by administering glucose tabs or sugar. The athlete should respond quickly. The athlete should decrease his or her level of exercise for 24 hours and monitor his or her blood sugar carefully.

If hypoglycemia persists despite dietary alterations, the athlete should consult his or her personal physician or the team physician about altering the amount of insulin taken.

Lightning Policy

The following are guidelines to determine the discontinuation of outdoor athletic practices during an electrical storm.

1. The coaching and athletic training staffs should monitor threatening weather conditions.
2. The **Head Coach and ATC's** are responsible for calling (discontinuing) practice.
3. Know the closest safe shelter to go to during an electrical storm. The NCAA Committee on Competitive Safeguards and Medical Aspects of Sports defines a safe shelter as "Any building normally occupied or frequently used by people, i.e., a building with plumbing and/or electrical wiring that acts to electrically ground the structure."
4. Use the "**flash-to-bang**" method to determine how close lightning is occurring (count the seconds between the time the lightning is seen to when the clap of thunder is heard – divide this number by five; this gives you how close the lightning is in miles).
5. If thunder can be heard, lightning is close enough to be a hazard and everyone should go to a safe location immediately.
6. The NSSL recommends the lightning and thunder should be stopped for 30 minutes after the last flash or lightning before returning to outdoor practice fields.

UNIVERSAL PRECAUTIONS

Universal precautions are to be used in the athletic training facility, and as such, all blood and other potentially infectious materials (OPIM) are to be treated as though they are infectious and precautions are taken accordingly. Saliva and gingival fluids are considered OPIM since they may often be contaminated with blood.

Emergency Plan for SAC

Address: Corner of College parkway and Briscoe drive

In the event that an emergency situation arises at the SAC the following steps should be taken:

- The status of the athlete should be determined by the on-site ATC. In the event there is no on-site ATC present then the coach should determine the status/responsiveness of the athlete. In the event of an unconscious, not breathing athlete EMS should be activated, CPR should be initiated, and the AED in the weight room should be utilized. A more detailed explanation of CPR protocols is listed on page 3 of this EAP.
- If it is determined that EMS needs to be contacted the on-site ATC or coach will remain with the athlete and instruct a teammate to find the nearest telephone (cellular or land-line) and call 911. That person will provide information concerning the name, age, sport, and condition affecting the athlete, the location/address of the SAC, and what entrance

the EMS personnel should use. The person making the phone call should stay on the phone until EMS arrives and designate another person to meet the EMS personnel at the main entrance of the SAC. The person meeting the EMS will show them to the injured athlete and fill them in on the current situation.

- Once EMS has arrived and taken over emergency duties for the ATC or coach the ATC will attempt to contact the parent or guardian of the injured athlete. In addition to this the ATC or coach will go to the hospital that the athlete has been transported to and bring with them the necessary insurance and medical history information from the ATR.

Emergency Plan for OVU Soccer/Softball Fields

Address: 1 campus view drive Parkersburg WV 26105

In the event that an emergency situation arises at the OVU Soccer/Softball Fields the following steps should be taken:

- The status of the athlete should be determined by the on-site ATC. In the event there is no on-site ATC present then the coach should determine the status/responsiveness of the athlete. In the event of an unconscious, not breathing athlete EMS should be activated, CPR should be initiated, and an AED utilized, if available. A more detailed explanation of CPR protocols is listed on page 3 of this EAP.
- If it is determined that EMS needs to be contacted the on-site ATC or coach will remain with the athlete and instruct the team's captain to find the nearest telephone (cellular or land-line) and call 911. That person will provide information concerning the name, age, sport, and condition affecting the athlete, the location/address of the OVU Soccer/Softball fields, and what entrance the EMS personnel should use. The person making the phone call should stay on the phone until EMS arrives and designate another person to meet the EMS personnel at the dirt road access by the softball field. The person meeting the EMS will show them to the injured athlete and fill them in on the current situation.
- Once EMS has arrived and taken over emergency duties for the ATC or coach the ATC will attempt to contact the parent or guardian of the injured athlete. In addition to this the ATC or coach will go to the hospital that the athlete has been transported to and bring with them the necessary insurance and medical history information from the ATR.

Emergency Plan for Jackson Park Softball Field

Address: off Rosemar Road

In the event that an emergency situation arises at Jackson Park Softball Field the following steps should be taken:

- The status of the athlete should be determined by the on-site ATC. In the event there is no on-site ATC present then the coach should determine the status/responsiveness of the athlete.

In the event of an unconscious, not breathing athlete EMS should be activated, CPR should be initiated, and an AED utilized, if available. A more detailed explanation of CPR protocols is listed on page 3 of this EAP.

- If it is determined that EMS needs to be contacted the on-site ATC or coach will remain with the athlete and instruct the team's captain to find the nearest telephone (cellular or land-line) and call 911. That person will provide information concerning the name, age,

sport, and condition affecting the athlete, the location/address of the Jackson Park Softball Field, and what entrance the EMS personnel should use. The person making the phone call should stay on the phone until EMS arrives and designate another person to meet the EMS personnel at the gate entrance. The person meeting the EMS will show them to the injured athlete and fill them in on the current situation.

- Once EMS has arrived and taken over emergency duties for the ATC or coach the ATC will attempt to contact the parent or guardian of the injured athlete. In addition to this the ATC or coach will go to the hospital that the athlete has been transported to and bring with them the necessary insurance and medical history information from the ATR.

Emergency Plan for City Park Baseball Field

Address: 1920 Park Ave, Parkersburg WV 26101

In the event that an emergency situation arises at City Park Baseball Field the following steps should be taken:

- The status of the athlete should be determined by the on-site ATC. In the event there is no on-site ATC present then the coach should determine the status/responsiveness of the athlete. In the event of an unconscious, not breathing athlete EMS should be activated, CPR should be initiated, and an AED utilized, if available. A more detailed explanation of CPR protocols is listed on page 3 of this EAP.
- If it is determined that EMS needs to be contacted the on-site ATC or coach will remain with the athlete and instruct the team's captain to find the nearest telephone (cellular or land-line) and call 911. That person will provide information concerning the name, age, sport, and condition affecting the athlete, the location/address of the City Park Baseball Field, and what entrance the EMS personnel should use. The person making the phone call should stay on the phone until EMS arrives and designate another person to meet the EMS personnel at the entrance of the baseball field. The person meeting the EMS will show them to the injured athlete and fill them in on the current situation.
- Once EMS has arrived and taken over emergency duties for the ATC or coach the ATC will attempt to contact the parent or guardian of the injured athlete. In addition to this the ATC or coach will go to the hospital that the athlete has been transported to and bring with them the necessary insurance and medical history information from the ATR.

Emergency Plan for Parkersburg High School

Address: Dudley Ave, Parkersburg WV

In the event that an emergency situation arises at the PHS the following steps should be taken:

- The status of the athlete should be determined by the on-site ATC. In the event there is no on-site ATC present then the coach should determine the status/responsiveness of the athlete. In the event of an unconscious, not breathing athlete EMS should be activated, CPR should be initiated, and the AED in the weight room should be utilized. A more detailed explanation of CPR protocols is listed on page 3 of this EAP.
- If it is determined that EMS needs to be contacted the on-site ATC or coach will remain with the athlete and instruct a teammate to find the nearest telephone (cellular or land-line) and call 911. That person will provide information concerning the name, age, sport, and condition affecting the athlete, the location/address of the SAC, and what entrance the EMS personnel should use. The person making the phone call should stay on the phone until EMS arrives and designate another person to meet the EMS personnel at the

main entrance of the SAC. The person meeting the EMS will show them to the injured athlete and fill them in on the current situation.

- Once EMS has arrived and taken over emergency duties for the ATC or coach the ATC will attempt to contact the parent or guardian of the injured athlete. In addition to this the ATC or coach will go to the hospital that the athlete has been transported to and bring with them the necessary insurance and medical history information from the ATR.

Doctor's signature _____