JESUIT HIGH SCHOOL ATHLETICS
SPORTS MEDICINE

Venue Emergency Action Plans
&
Policies and Procedures

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ATHLETIC TRAINER JOB DESCRIPTION

The athletic trainer (ATC) reports to the Athletic Director (AD). The ATC attends scheduled practices and interscholastic athletic contests and coordinates with the AD based on the athletic training coverage available per week dependent on the sports. Any additional athletic training coverage is to be planned ahead of time between the AD and ATC. The responsibilities of the ATC shall include, but may not be limited to the following:

1. Possess a Board of Certification (BOC) certification and fulfill the requirements to hold a current OR ATC state license.
2. 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.
3. Coordinate with team physician to provide:
    a. Coverage for home varsity football games
    b. On site visits to evaluate and treat athletes from all sports when needed
    c. Follow-up injury care after physician's visits as needed
    d. Therapeutic rehabilitation
    e. Assistance on all matters pertaining to the health and well-being of student athletes
4. Determine when an athlete may safely return to full participation from an injury. (following a physician's authorization when needed)
5. Maintain complete records of all athletic injuries and treatments rendered.
6. Notify parents or legal guardian and recommend appropriate medical care when the ATC deems a significant injury has occurred.
7. Communicate with coaching staff regarding student athlete's injury status.
8. Provide assistance to the coaching staff in the development and implementation of injury prevention and strength and conditioning programs.
9. Supervise athletic training room (ATR)
10. Select and maintain equipment and supplies necessary to run an athletic training room and provide appropriate care.

RELATIONSHIPS AND RESPONSIBILITIES

1) ATC and Student Athletes
    a. The main concern of the ATC should be the health of the student athlete.
    b. The student athlete is to report health concerns, including injury, to the ATC as soon as possible.
    c. Only important and medically necessary information regarding the injury will be shared with the coach.
    d. Parents of the injured student athlete will be notified as soon as possible after significant injury has occurred.
    e. The student athlete is responsible for follow-up treatment of his/ her injury.
    f. The student athlete may be medically disqualified from play if treatment requirements and/or full clearance from a physician is not met.
2) Coach and Athletic Training Students (ATS)
    a. The ATS works under the direct supervision of the ATC.
    b. Under NO circumstances is the ATS to communicate athlete information to anyone other than the ATC unless directed by the ATC.
    c. The ATS must NEVER be allowed to make return to play decisions, analyze or diagnose injuries, or assist in the treatment of athletic injuries except under the direct supervision of the ATC.
3) ATC and Coaches
    a. All medical decision will go through the ATC.
    b. The ATC will communicate with the coaches about injured athletes.
    c. If a coach seeks further clarification regarding a student-athlete's status, they are responsible for contacting the ATC to further discuss.
4) ATC, Coaches, and Visiting Teams
    a. Visiting teams should be made aware of the availability of medical personnel on site, prior to the game starting.
    b. If a visiting team is travelling with their own ATC, they will assume medical responsibility for their team. Jesuit personnel will be available to lend assistance as needed.
5) ATC and Physician
    a. The ATC works under and in conjunction with the team physician as well as community physicians in caring for student athletes.
    b. The ATC and physician will work together in developing treatment programs as necessary for student athlete's safe return to activity.
    c. When a team physician is present at an athletic event, the final decision regarding the status of the student athlete will be made in conjunction between the physician and ATC.
6) ATC and Parent
    a. It is the responsibility of the ATC to contact the parent/guardian after a significant injury has been sustained.
    b. The ATC will inform the parent/ guardian about the injury and necessity for referral as indicated.
    c. All parent/guardian questions shall be answered by the ATC in a timely manner

d. Ultimately parents/ guardians have the final say regarding any healthcare decisions for their son/ daughter, but the ATC can medically disqualify a student athlete until they are seen by a physician, and meet return to play criteria outlined in this manual.
e. The ATC and parents/ guardians should work together to insure a safe return to play for the student athlete.

7) ATC and Administration
   a. To work in conjunction to review and update all policies and procedures relating to the sports medicine program EAP/ policies and procedures for Jesuit athletics as needed.
   b. Work together on implementing and communicating policy and procedures to coaching staffs/ parents and other school staff as necessary.
   c. Assist with care and organization of necessary needs for student athletes/ parents and Jesuit staff in the event of any catastrophic athletic injury.
   d. Review any EAP activation scenario and document any necessary changes or updates that may be necessary based on each situation.

PRACTICE AND GAME PROCEDURES FOR AN INJURED OR ILL STUDENT ATHLETE

Decisions regarding the availability of the student athlete for practice or game competition require the cooperative efforts of the student athlete, coach, ATC, 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 ATC will attempt to provide quality athletic health care for the student athlete under the following guidelines.

1) If a student athlete is under the care of a physician, or a physician is present, the physician, in conjunction with the ATC, determines the ability of the student athlete to practice or compete in practice or game.
2) If the student athlete is NOT under a physician's care, and the ATC is providing the primary care, the ATC determines the ability of the student athlete to practice or compete.
    a. The ATC will convey a "no-play" decision to the appropriate coach.
    b. Under no circumstances should the coach allow the student athlete to practice or compete until they are cleared by the ATC.
        i. Direct verbal communication or written documentation is required for full clearance to return to play for significant time loss injuries that are under the care of a physician.
        ii. A "no-play" decision by the physician will always be followed.
3) Under no circumstances shall the coach allow a student athlete to practice/ compete when a "no-play" decision from the ATC or physician is in effect.
    a. Should a coach or student athlete desire to disregard the "no-play" order, the AD will be contacted and will determine the appropriate course of action.
    b. Coaches will NOT refer student athletes out to physicians, medical providers. The first and only referral by a coach is to be to the ATC (Excluding 911/ EMS emergencies).
        i. If the ATC is unavailable the coach will inform the athlete's parent/guardian of the injury and fill out a district incident form, along with notifying the ATC/AD about the student athlete.
4) If a "no-play" is in place, the student athlete may be able to perform rehabilitation of the injury and is expected to report to the ATR for treatments.
5) Medical referral and continued care:
    a. At the time of the comprehensive examination of the injury, the ATC will present his/her opinion on the need for a further medical referral to the appropriate medical professional.
    b. Parents/ guardian will be notified if there is a need for a medical referral.
        i. ATC will give advice about the type of physician, or medical provider that would best suit the student athlete's needs.
    c. The final decision rests with the parent/guardian, if the parent/guardian disregards the referral the student athlete may be medically disqualified until they are seen by an appropriate medical professional.

d. The student athlete and his/her parents are responsible for providing the ATC with any written documentation from the treating physician regarding clinical diagnosis, return to play status/timeline, and/or rehabilitation guidelines.
e. In the event an injured student athlete sees a physician without prior knowledge of the ATC, the athlete must provide a written report of the findings from a qualified medical professional. If this is not provided, the student athlete will not be permitted to practice/ compete until the report is filed with the ATC and they have met return to play criteria (outlined on page 9)
f. Continued care of the student athlete is carried out in the form of re-evaluations of the student athlete's progress, daily treatments and rehabilitation.
g. Where needed and available, such care is performed with periodic consultation with qualified medical professionals, and attending physician.

6) ATC Present- In the event an injury occurs while the ATC is present at either a home or away event the following protocol exists:
   a. The ATC will perform an initial evaluation of the student athlete and determine the severity
   b. The determination of a student athlete's ability to continue is made solely by the ATC in the absence of a physician.
   c. Should the injury warrant immediate medical attention, the ATC will decide on the best means of transport and care.
7) ATC NOT Present-In the event an injury occurs while the ATC is NOT present at either a home or away event the following protocol exists:
   a. If the ATC is on campus, but not immediately present
      i. The coach should contact the ATC by the quickest available means, via cell phone/landline, radios, or by designating a coach or student to summon the athletic trainer.
   b. If the ATC is not on campus.
      i. The coach should provide initial first aid if necessary.
      ii. Activate EMS if it is immediately necessary.
      iii. Contact the athlete's parent/ guardian and inform them of the injury
      iv. Fill-out and incident report and inform the ATC/ AD of the incident via email.
      v. ATC will follow up with Athlete/ parent as needed for return to play guidance.
   c. Away Event
      i. The attending coach must adhere to the recommendations of the host ATC or licensed medical personnel.
      ii. 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. Please refer to general emergency procedures for help with first aid protocol.
      iii. The injured athlete should be directed to see the ATC as soon as possible before the next practice or contest

8) Physician Attendance/ Paramedic coverage
    a. Jesuit will have limited direct physician coverage because of schedules and number of athletic events. Currently physician coverage is for Varsity football games. ALS coverage will not be on site during athletic events because of the close proximity to Jesuit high school.

GENERAL RETURN TO PLAY PROTOCOL

All student athletes who have sustained an injury must be cleared by the ATC and physician in order to return to play. Student athletes under the care of a physician must receive written clearance before returning to full sports participation. Regardless of clearance from a physician, a student athlete wishing to return to play must also adhere to this protocol.

The following is a standard protocol for releasing a student athlete to return to play:

1) Student athlete should achieve a functional range of motion bilaterally equal in order to be eligible to return to play.
2) Student athlete should have adequate strength bilaterally in order to be eligible to return to play.
3) Student athletes returning from a time loss injury should pass sport specific functional testing before full return to play.
4) Student athletes and parents will be educated regarding the risks involved in returning to sport after the injury and should be ready to adapt to the physical demands of their sport in relation to their injury.
5) If ATC decides that continued play with injury is detrimental to the student athlete, regardless of physician clearance, student athlete will remain under no-play/ practice status until ATC can contact physician or medical provider and get clarification on exact findings of the medical providers evaluation.

Jesuit High School Lightning EAP

Jesuit High School Lightning EAP assumes 1 Athletic trainer, 1 Coach, and 1 Administrator/ Event Coordinator are in attendance

ATC Role and Responsibilities:

- The ATC will evaluate the information based on the potential threat of a thunder/ lightning storm prior to the beginning of a competition.
- The ATC will work in conjunction with the event coordinator/ ATS to monitor the weather progression throughout competition and practices via the National Weather Service for the local area.
- The ATC will make the final decision to remove individuals from the field or activity.
    - The ATC will have UNCHALLENGABLE authority to suspend activity in the event of having to initiate the Lightning EAP.
    - The ATC will also have the UNCHALLENGABLE authority to resume activity when the field and conditions are safe according to the NATA position statement & OSAA guidelines.

Event Coordinator/Administrator Role and Responsibilities:

- They will be the designated weather watchers in the event of a potential thunder/ lightning storm.
- Prior to competition/ practice they will work in conjunction with the ATC to monitor the weather progression throughout competition and practices via the National Weather Service for the local area.
- They are responsible for letting the announcers/ coaches know that play has been suspended by the ATC.
- They will then assist with directing spectators and teams to the designated safe zone.
- In the event the ATC has given the okay to resume activity the event coordinator will be responsible for letting the announcer/ coaches know that it is safe to return to the competitions and or practices.

LIGHTNING POLICY

- If thunder/ lightning is heard and or seen, the Lightning EAP will be activated and fields will be cleared of all athletes/ spectators.
    - Based on NATA guidelines/ OSAA guidelines
- Activities should be suspended until 30 minutes after the last strike of lightning is seen (or at least 5 nmi away) and after the last sound of thunder is heard. This 30-minute clock restarts for each lightning flash within 10 nmi and each time thunder is heard.
    - Based on NATA guidelines/ OSAA guidelines

DESIGNATED SAFE ZONE – Jesuit High School

- In the event of a thunder/lightning storm the Knight Gym, and Knight Gym lobby will serve as the emergency safe zone for spectators and individuals who are outside. If events are going on teams will use their dedicated teams' room, while spectators will be given the option of going into the designated safe zone.

Heat Illness Policy

Plan Assumes 1 ATC, Coaching Staffs, School Nurse, AD are on staff during the course of the academic/ athletic calendar year. All coaches will have completed heat acclimatization course prior to being in contact with athletes per the OSAA/ JHS athletics office.

1. The ATC will check the OSAA heat index calculator prior to practices and competitions when there is a potential threat of heat illness based on the weather.
    a. The ATC will keep a log of these days per the OSAA.
    b. Per the OSAA heat index, the ATC will stay in contact with AD and coaching staffs about changes in practice schedules based on the OSAA heat index calculation practice guidelines.
2. The ATC will take a WBGT measurement prior to the start of practices and competitions when there is a potential threat of heat illness based on the weather.
    a. The ATC will keep a log of those days and assist with making practice change recommendations.
    b. In conjunction with the OSAA heat index, the ATC will stay in contact with AD and coaching staffs regarding any changes to practice/games that would be applicable for the WBGT readings/ recommendations as outlined in Appendix A, Cat 1. If a WBGT is accessible and on site.
3. Physical exertion and training activities should begin slowly and gradually increase.
    a. Begin with shorter less intense practices, with longer recovery periods
    b. Minimize unnecessary protective gear during first several practices and gradually increase gear each practice.
    c. Emphasize instruction over conditioning
4. Keep each athlete's individual conditioning and medical status in mind and adjust accordingly. These factors directly affect exertional heat illness risk.
5. Adjust intensity (lower) and rest breaks (increase frequency/duration), and consider reducing uniform and protective gear as conditions are increasingly warm/ humid, especially if the weather changes from the previous few days.
6. Recognize early signs of distress and heat illness, promptly adjust activity and treat appropriately. First aid should not be delayed!
7. Recognize more serious signs of heat illness (clumsiness, stumbling, collapse, obvious behavioral changes and or central nervous system problems). Immediately stop activity and activate Venue specific Emergency action plan protocols. Begin on-site rapid cooling.
8. Once the Emergency action plan has been initiated an injury/incident report will be completed within 48 hours of each incident. The ATC will meet with the AD in order to review the EAP process and the injury report.

*If applicable use a Wet Bulb Globe Thermometer to determine actual temperature on the artificial turf playing surface prior to the start of an event. WBGT is a more accurate measure of environmental heat stress in direct sunlight while the heat index accounts for heat stress in the shade.

Exertional Heat Stroke EAP

Considerations for potential EHS emergencies

1. The ATC will designate the appropriate personnel to aid in set up of cooling station prior to games or practice in which the forecasted heat index is above 80 degrees, in agreement with OSAA heat index policy (notice, caution, warning, danger zones).
2. Jesuit High School athletics will follow the OSAA heat index policies and procedures in regard to monitoring heat index and practice/game modifications.

OSAA Heat Index Policy

Heat Index

Schools shall monitor the heat index for their geographic area prior to practices. Outlined below are the steps that each member school shall take in order to implement this policy.

NOTE: This policy applies to all OSAA sanctioned sports and activities in all seasons. Indoor activities where air conditioning is available are not bound by this policy.

1. **Subscribe:** Athletic Directors and Coaches shall subscribe to receive OSAA Heat Index Notifications at www.osaa.org/heat-index. An OSAA Heat Index Notification is generated for areas where the forecasted high temperature and relative humidity indicate a forecasted heat index that may require practice modifications. Only those areas that have a forecasted heat index of 95°F or higher receive alerts. Notifications are sent daily via e-mail and/or SMS to subscribers.
2. **Designate:** Schools shall designate someone who will take the necessary steps to determine and record the heat index for your geographic area within one hour of the start of each team's practice. This is only necessary on days when the school receives an OSAA Heat Index Notification. Depending on practice schedules, it is possible that the designated person will have to record the Heat Index multiple times on the same day.
3. **Calculate:** Within one hour of each team's practice on days when the school's subscribers receive an OSAA Heat Index Notification, the designated person shall utilize the OSAA Heat Index Calculator to determine the actual heat index.
4. **Record:** If the actual heat index is 95°F or higher, the designated person shall record it using the OSAA Heat Index Record or by printing out a copy to be kept at the school for inspection at the request of the OSAA. A separate record shall be kept for each fall sport at each level. Practice modification, as necessary, shall also be recorded. If the actual heat index is less than 95°F, no action is needed.
    a. **Act:** If the actual heat index is 95°F or higher, activity should be altered and/or eliminated using the following guidelines:
5. **Danger: Heat Index ≥ 105°F**
6. OSAA Recommendation: Stop all outside activity in practice and/or play, and stop all inside activity if air conditioning is unavailable.
7. **Warning: Heat Index ≥ 100°F and < 105°F**
    a. OSAA Recommendation: Postpone practice to later in the day.
    b. Maximum of 5 hours of practice per day.
    c. Practice length a maximum of 3 hours.
    d. Mandatory 3 hour recovery period between practices.

e. Alter uniform by removing items if possible - allow for changes to dry t-shirts and shorts.
f. Contact sports and activities with additional equipment - helmets and other possible equipment removed if not involved in contact or necessary for safety.
g. Reduce time of planned outside activity as well as indoor activity if air conditioning is unavailable.
h. Provide ample amounts of water.
i. Water shall always be available and athletes should be able to take in as much water as they desire.
j. Watch/monitor athletes for necessary action.

8. **Caution: Heat Index ≥ 95°F and < 100°F**
    a. OSAA Recommendation: Consider postponing practice to later in the day.
    b. Maximum of 5 hours of practice per day.
    c. Practice length a maximum of 3 hours.
    d. Mandatory 3 hour recovery period between practices.
    e. Contact sports and activities with additional equipment - helmets and other possible equipment removed if not involved in contact or necessary for safety.
    f. Provide ample amounts of water.
    g. Water shall always be available and athletes should be able to take in as much water as they desire.
    h. Watch/monitor athletes for necessary action.
9. **Notice: Heat Index ≥ 80°F and < 95°F**
    a. Maximum of 5 hours of practice per day.
    b. Provide ample amounts of water.
    c. Water should always be available and athletes should be able to take in as much water as they desire.
    d. Watch/monitor athletes for necessary action.
10. **Safe: Heat Index < 80°F**
    a. Maximum of 5 hours of practice per day.
    b. Provide ample amounts of water.

Recognition

1. Any athlete with signs or symptoms of central nervous system dysfunction during exercise in the heat should be suspected to be suffering from EHS until a rectal temperature confirms or refutes this diagnosis.
2. Patients with suspected EHS will have a temperature obtained via rectal thermometer by the ATC.
    a. Rectal thermometers may include a traditional thermometer (e.g. small, discrete), electronic thermometers with a rigid end (e.g. hand-held digital thermometer) or a thermistor (e.g. long, flexible thermistor)
    b. It is important to reiterate that during and following intense exercise in the heat, temporal, aural, oral, skin, axillary and tympanic temperature are <u>not</u> valid and should **never** be utilized in evaluating a potential exertional heat stroke

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

Cooling

1. If rectal temperature is between 102∞-104∞F, initiate cooling via rotating cold wet or cold water immersion.
2. If rectal temperature is at or above 104∞F, initiate the exertional heat stroke treatment protocol and contact EMS services immediately.
3. The patient must be moved to a cooling zone, begin appropriate treatment and continuously monitor the patient.
    a. For use of a traditional thermometer or a hand-held digital thermometer (any thermometer with a rigid end), obtain initial temperature, remove device, and calculate cooling rate (approximately 1∞F every 3-5 minutes when using cold water immersion). When the ATC believes the temperature is within a safe range, remove patient from tub, and re-insert probe to confirm temperature. If temperature is not within the safe range, cooling will

continue. Repeat procedure until temperature is confirmed to be within the safe range.

   b. For use of a flexible thermistor, keep the probe in for the duration of treatment.
4. Excess clothing shall be removed to aid cooling.
   a. If removal of clothing and/or equipment would cause delays of 5+ minutes, do not remove, instead initiate cooling immediately.
5. Place patient in a cold-water (35-59∞F) tub up to the neck.
   a. Wrap a towel across the chest and beneath both arms to prevent the athlete from sliding into the tub.
   b. Ice shall cover the surface of the water at all times.
   c. Water shall be continuously and vigorously stirred to maximize cooling.
   d. An ice-cold towel will be placed over the head/neck and rewet and replaced every 2 minutes.
   e. Cooling shall cease when body temperature reaches 102∞F.
6. Cold Water Immersion (CWI) Tub
   a. Proper set-up includes:
      i. A tub filled with water.
      ii. Chests filled with ice next to the tub ready for treatment.
      iii. Available bed sheet or large towels.
      iv. Towels for placement over the head and neck.
      v. Completion of set-up within 5-10 minutes prior to the practice/competition/event site.
7. Cool First, Transport Second
   a. When a patient is diagnosed with EHS, the principle of Cool First, Transport Second will be used.
      i. Note: EMS should not transport the patient until they reach 102∞F due to the inability to continue vigorous cooling in the ambulance

Vital sign monitoring

1. The ATC will monitor vital signs including core body (rectal) temperature, heart rate, blood pressure and other vital signs.

Calling EMS

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

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

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

Jesuit High School Sport Medicine Air Quality Index Guidelines

These air quality guidelines, were created in consultation with the Oregon Health Authority (OHA), to provide a default policy to those responsible for sharing duties for making decisions concerning the cancelation, suspension, and/or restarting of practices and contests based on poor air quality.

Air quality will be observed and managed by the athletic trainer and the athletic director. In the event of potential air quality issues, the Air Quality Index (AQI) should be monitored throughout the day, and during an event, to have the best data possible to make informed decisions about conducting practices and competitions. The AD and ATC will review the AQI information for all regions throughout the state on either the Oregon Department of Environmental Quality (DEQ) website at https://oraqi.deq.state.or.us/home/map, the Oregon DEQ app "OregonAir", or on the Environmental Protection Agency (EPA) Air Now website at https://airnow.gov to determine if action or changes to athletic scheduels is necessary (see chart below).

Areas Without Air Reporting Stations: Given the random behavior of factors related to the calculation of the AQI levels in different areas of the state (wind speed and direction) member schools not near a reporting station should consult with local state and/or federal authorities to help determine the AQI level in your specific area. If air monitoring equipment is not available, member schools should utilize the 5-3-1 Visibility Index to determine air quality.

Air Quality Index (AQI)	5-3-1 Visibility Index	Required Actions for Outdoor Activities
51 - 100	5-15 Miles	***Students who are unusually sensitive to air pollution should consider indoor activities only.*** Athletes with asthma should have rescue inhalers readily available and pretreat before exercise ***if*** directed by their healthcare provider. All athletes with respiratory illness, asthma, lung or heart disease should monitor symptoms and reduce/cease activity if symptoms arise. Increase rest periods as needed.
101 - 150	3-5 Miles	Because they involve strenuous activity for prolonged periods of time, all outdoor ***contests*** shall be canceled or moved to an area with a lower AQI. ***Consider moving*** practices indoors, if available. Be aware that, depending on a venue's ventilation system, indoor air quality levels can approach outdoor levels. ***Practice shall be no longer than 90 minutes total for the day. Level of activity should be less than "normal" practice session and include rest periods. Students who are unusually sensitive to air pollution should consider indoor activities only. Athletes with asthma should have rescue inhalers readily available and pretreat before exercise if directed by their healthcare provider. All athletes with respiratory illness, asthma, lung or heart disease should monitor symptoms and reduce/cease activity if symptoms arise.***
151 - 200	1-3 Miles	Because they involve strenuous activity for prolonged periods of time, all outdoor activities (practice and competition) shall be canceled or moved to an area with a

		lower AQI. Move practices indoors, if available. Be aware that, depending on a venue's ventilation system, indoor air quality levels can approach outdoor levels.
>200	1 Mile	Because they involve strenuous activity for prolonged periods of time, all outdoor activities (practice and competition) shall be canceled or moved to an area with a lower AQI. Move practices indoors, if available. Be aware that, depending on a venue's ventilation system, indoor air quality levels can approach outdoor levels.

1. 5-3-1 Visibility Index: Making visual observations using the 5-3-1 Visibility Index is a simple way to estimate air quality and know what precautions to take. While this method can be useful, you should always use caution and avoid going outside if visibility is limited, especially if you are sensitive to smoke

    1. Determine the limit of your visual range by looking for distant targets or familiar landmarks such as mountains, mesas, hills, or buildings at known distances. The visual range is that point at which these targets are no longer visible. As a rule of thumb: If you can clearly see the outlines of individual trees on the horizon it is generally less than five miles away. It is highly recommended that schools use pre-determined landmarks that were established on a clear day to determine their visual range.
    2. Ideally, the viewing of any distant targets should be made with the sun behind you. Looking into the sun or at an angle increases the ability of sunlight to reflect off of the smoke, thus making the visibility estimate less reliable.
    3. Be aware that conditions may change rapidly and always use the more conservative of multiple metrics (AQI, 5-3-1 Visibility Index, etc.).

D. **Act:** This chart will help determine the action needed based on the air quality in your area.

E. **Additional Resources:** Schools may also refer to OHA's fact sheet regarding School Outdoor Activities During Wildfire Events at https://apps.state.or.us/Forms/Served/le8815h.pdf.

Jesuit High School Sports Medicine Spine Injury Management Protocol

August 2021

General Guidelines

- Any athlete suspected of having a spinal injury should initially not be moved and should be managed as though a spinal injury exists. C-spine in-line stabilization should be maintained.
- The primary acute treatment goals are to ensure that the cervical spine is immobilized in neutral and vital life functions are accessible. The athlete's airway, breathing, circulation, level of consciousness (AVPU) and neurological status should be assessed. If airway is impaired, maintain c-spine in-line stabilization simultaneously with airway using a modified jaw thrust maneuver. If the athlete's breathing is inadequate, assist ventilations with bag-valve-mask, airway adjuncts as appropriate, and supplemental oxygen.
- During the initial assessment, the presence of any of the following, alone or in combination, requires the initiation of the spine injury management protocol: unconsciousness or altered level of consciousness, bilateral neurological findings or complaints, significant midline spine pain with or without palpation, or obvious spinal column deformity.
- EMS should be activated.
- The athlete should not be moved until immobilized unless absolutely essential to maintain airway, breathing and circulation. If the athlete must be moved, the athlete should be placed in a supine position while maintaining spinal immobilization.
- In a situation where it may not be appropriate for on-site medical personnel to transfer the athlete to a long spine board prior to EMS arrival (lack of enough qualified help or other factors), the rescuer(s) should maintain in-line stabilization, place a rigid cervical collar on (if possible), support ABCs, and continue to monitor baseline vital signs and complete secondary evaluation while awaiting EMS.

Spine Immobilization

- If the spine is not in a neutral position, rescuers should realign the c-spine to minimize secondary injury to the spinal cord and to allow for optimal airway management. However, the presence or development of any of the following, alone or in combination, represents a contraindication for moving the c-spine to neutral position:
    - Movement causes increased pain, neurological symptoms, muscle spasm or airway compromise;
    - Resistance is encountered during the attempt at realignment; or
    - The athlete expresses apprehension.
- If possible, a correctly sized rigid cervical collar should be placed on athlete prior to moving.
- When moving a suspected spine-injured athlete, the head and trunk should be moved as a unit by securing the athlete to a rigid immobilization device (i.e. long spine board, scoop stretcher, or full body vacuum mattress). Either the 8-person lift, one of the various log roll maneuvers, or scoop stretcher should be used to place the athlete on the rigid immobilization device. It is ideal that at minimum three (3) rescuers with preferably five to six (5-6) be in place to perform the log roll procedure and that at minimum eight (8) rescuers be in place to perform the 8-person lift. Rescuers should select the most appropriate transfer techniques which best fits the individual circumstances associated with

each athlete (i.e. position: supine or prone, number of rescuers available, space available, etc…).

- The rescuer controlling c-spine stabilization will be in command of 8-person lift or log roll maneuvers and transfer to rigid immobilization device.
- Once positioned onto long spine board, the athlete's torso and legs should first be secured, using spider straps or speed clips (if speed clips are used, ideally 7 straps should be applied: 2 crossing chest from shoulder to opposite axilla, one across chest under axilla, 1 across the abdomen, 1 across the pelvis, 1 across the mid thighs and 1 across the mid tibias). Athlete's arms should be left free from long spine board straps to facilitate vital sign monitoring and IV access. The athlete's wrists may be secured together in front of the body with velcro strap or tape once secured to the rigid immobilization device.
- Once torso and legs are secured, the head should be secured last. If necessary, padding should be applied under the athlete's head to fill any voids and maintain neutral in-line position. The head should be secured with lateral restraint pads and then secured to board with tape over forehead and at chin.
- Following securing athlete to board, neurological status should be reassessed.
- The secondary survey should be completed with baseline vital signs (reassessed regularly), head-to-toe survey, and SAMPLE history.
- Athlete should be transported to the most appropriate emergency medical facility and head team physician and appropriate subspecialist(s) notified.
- Parent/ Guardian will be notified by a school official once the athlete is stabilized and transported.

Additional Guidelines For Care of Spine-Injured Football Athlete

In an emergency situation with equipment intensive sports, the protective equipment should be removed prior to ambulance transport to the hospital. The rationale for consideration of equipment removal on the field is based upon four concepts:

- **Advances in equipment technology**: changes in helmet and shoulder pad design have helped to facilitate equipment removal
- **Equipment removal should be performed by those with highest level of training**: On the field of play there may be multiple individuals (athletic trainers, emergency medical technicians, physicians) with knowledge of equipment removal versus the hospital emergency department (ED)
- **Better packaging**: with both the helmet and shoulder pads removed, the athlete is in a spine neutral position. A cervical collar may be applied. Packaging straps are closer to body with equipment removed.
- **Expedited care in ED**: with equipment removed prior to arrival in ED, physician evaluation and diagnostic tests may be expedited

Factors to consider in equipment removal include the nature of the injury, type of protective equipment worn (helmet, shoulder pads, neck roll, rib pads…), the number of rescuers on-site, and the level of training of rescuers in equipment removal. The Greek physician Hippocrates, in his writing Epidemics, is credited with the medical dictum "to do good or to do no harm". Protective equipment left in place following a spine injury may impede the evaluation and treatment process, while inappropriately removed protective equipment may cause spinal

movement, potentially causing harm. As protective equipment varies by sport and types of equipment differ, rescuers must be familiar with both the types of equipment and removal techniques in order "to do good or to do no harm".

Equipment removal should be done by at least three rescuers trained and experienced with equipment removal at the earliest possible time. If fewer than three people are present, the equipment should be removed at the earliest possible time after enough trained individuals arrive. Rescuers should utilize a medical time out pre-activity session to plan out the options with the personnel available for that practice/game. Clinical judgment in each situation may recommend something different than this best practices recommendation (i.e. changes in clinical status, equipment failure, space barriers, etc…). Rescuers should be able to recognize when is it NOT appropriate to remove equipment on the field of play and have a plan to best manage the patient.

General Principles of Helmet and Shoulder Pad Removal

The helmet should be removed first, followed by the shoulder pads. Once the shoulder pads are removed, rescuers should properly fit and apply a cervical collar. The athlete should then be secured to a rigid immobilization device (i.e. spine board, scoop stretcher, or full body vacuum mattress).

Helmet removal technique:

- Rescuer 1 stabilizes c-spine
- Rescuer 2 assumes c-spine control from front, allowing Rescuer 1 to release: "I have c-spine control; you can release"
- Rescuer 1 removes helmet; then again assumes c-spine control, allowing Rescuer 2 to release: "I have c-spine control; you can release"

Shoulder pad removal techniques:

Several techniques exist to remove shoulder pads (<u>following helmet removal</u>). Rescuers should select the techniques which best fits the individual circumstances associated with each athlete.

- Supine athlete:
  - <u>8 Person Lift</u> (formerly referred to as lift and slide or levitation technique): Rescuer 1 stabilizes c-spine; jersey and shoulder pads cut in front; Rescuers 2-7 (3 on each side) lift athlete 12" on command (to allow shoulder pad clearance for removal); Rescuer 8 slides board in; Rescuer 9 carefully removes shoulder pads without interfering with Rescuer 1's c-spine control. One Rescuer 9 communicates "shoulder pads are clear", the athlete is lowered to board on command.
  - <u>Tilt Technique</u> (also known as elevated torso): Rescuer 1 reaches inside shoulder pads and stabilizes c-spine from front. Rescuers 2-3 tilt athlete to 50 degrees at waist, similar to motion of a "sit-up". Rescuer 4 removes shoulder pads from over top of head. Rescuer 4

then grasps both sides of head and assists Rescuer 1 with c-spine stabilization as the athlete is lowered down. Note that the tilt should not be utilized as a shoulder pad removal technique with suspected concomitant thoracic and/or lumbar injury.

- Straddle technique (also known as lift and slide): may be utilized with small athletes. Rescuer 1 stabilizes c-spine; jersey and shoulder pads cut in front; Rescuers 2-4 standing over straddling the athlete lift athlete 12" on command (to allow shoulder pad clearance for removal); Rescuer 5 slides board in; Rescuer 6 carefully removes shoulder pads without interfering with Rescuer 1's c-spine control. Once Rescuer 6 communicates "shoulder pads are clear", the athlete is lowered to board on command
- Flat Torso Technique: Jersey and shoulder pads are cut in front. Rescuer 1 reaches inside shoulder pads and stabilizes c-spine from front. Rescuers 2-3 grasp shoulder pads from either side of athlete and slide pads out in an axial direction.
- Log Roll Technique: A standard log roll technique is utilized. Rescuer 1 stabilizes c-spine. Rescuers 2-4 perform supine log roll, pausing at the top of the roll. Rescuer 5 cuts the jersey and shoulder pads in back, then positions spine board and athlete is lowered down onto board. The jersey and shoulder pads are then cut in the front and the bi-valved shoulder pads are removed from each side by Rescuers 2 and 3 while Rescuer 1 continues to stabilize c-spine.
- Quick Release Shoulder Pads: one shoulder pad manufacturer currently makes a quick release shoulder pad. Rescuer 1 stabilizes c-spine. The jersey and shoulder pads are cut in front. Rescuer 2 cuts the emergency quick release tab and pulls a cable which release the shoulder pads in back. The bi-valved shoulder pads are removed from each side by Rescuers 2 and 3 while Rescuer 1 continues to stabilize c-spine.

- Prone athlete: The prone athlete must be log rolled as the 8-person lift and scoop stretcher techniques may only be utilized on supine athletes. Rescuers should select either the log roll-push or log roll-pull technique based upon the individual circumstances associated with each athlete.
  - Rescuer 1 stabilizes c-spine. Prior to initiating the log roll, Rescuer 2 cuts the jersey and shoulder pads in back, then positions spine board and athlete is lowered down onto board by Rescuers 3-5. The jersey and shoulder pads cut in front by Rescuer 2 and the bi-valved shoulder pads are removed from each side by Rescuers 2 and 3.

At a minimum, the facemask should be removed prior to transportation, regardless of current respiratory status. Tools for facemask removal (power screwdriver, FM Extractor, Anvil Pruners, or ratcheting PVC pipe cutter) should be readily accessible. If possible, consideration should be given to the use of quick release facemask clips to facilitate facemask removal.

Procedures for Training in Spine Immobilization:

On at least an annual basis, personnel should review signs and symptoms of spine injury and complete a training session each year with in-line stabilization, rigid cervical collar application, log roll maneuver (supine and prone), 8-person lift maneuver, equipment removal techniques, rigid immobilization device packaging. Additionally, personnel providing football medical coverage should review facemask removal with appropriate tools, helmet removal and shoulder pad removal.

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Jesuit High School Concussion Policy

Jesuit High School has developed this protocol to educate coaches, school personnel, parents, and athletes about appropriate concussion management. This protocol outlines procedures for staff to follow in managing concussion and outlines school policy as it pertains to return to play following a concussion.

A safe return to activity is important for all athletes following any injury, but it is essential after a concussion. The following procedures have been developed to ensure that concussed athletes are identified, treated, and referred appropriately. Consistent application of this protocol will ensure the athlete receives appropriate follow-up medical care and/or academic accommodations and ensures the athlete is fully recovered prior to returning to activity.

Recognition of Concussion

These signs and symptoms – following a witnessed or suspected blow to the head or body- are indicative of a probable concussion.

Signs (observed by others):	**Symptoms (reported by athlete):**
Appears dazed or stunned	Headache
Exhibits confusion	Fatigue
Forgets plays	Nausea or vomiting
Unsure about game, score, opponent	Double vision, blurry vision
Moves clumsily (altered coordination)	Sensitive to light or noise
Balance problems	Feels sluggish
Personality changes	Feels foggy
Responds slowly to questions	Problems concentrating
Forgets events after the hit	Problems remembering
Forgets events prior to hit	Balance difficulties
Loss of consciousness (any duration)	Sleep disturbances

Any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion must be removed immediately from the competition or practice and will not be allowed to return to play until cleared by an appropriate health care professional (per Max's Law, approved by Oregon Legislature in 2009).

Management and Referral Guidelines for All Staff

1. The following situations indicate a medical emergency and require the activation of the Emergency Medical System:
    a. Any athlete with a witnessed loss of consciousness (LOC) of any duration should be spine boarded and transported immediately to the nearest emergency department via emergency vehicle if the athletic trainer is not immediately available for on field evaluation.
    b. Any athlete who has symptoms of concussion that are worsening, or displays the following symptoms will be advised to seek further evaluation at the emergency department immediately.
        i. Deterioration of neurological function

ii. Decreased level of consciousness
iii. Decrease or irregularity in respirations
iv. Any signs or symptoms of associated emergent injuries, spine or skull fracture, or bleeding
v. Mental status changes: lethargy, difficulty maintaining arousal, confusion, or agitation
vi. Seizure activity

2. The parents of a stable (not worsening) athlete will be educated regarding red flags that would indicate immediate medical attention.
3. An athlete who has sustained a concussion will be sent home with a responsible adult who has been educated on home instructions and follow up procedures.

Guidelines and Procedures for Coaches
Recognize concussion and remove from activity

1. All coaches should become familiar with the signs and symptoms of concussion and will remove any athlete exhibiting signs, symptoms, or behaviors consistent with a concussion (such as LOC, headache, dizziness, confusion, or balance problems, etc). The athlete will not be allowed to return to play until cleared by both the ATC and a designated health care professional as dictated by Max's Law (MD, PA, DO, NP, Psychologist).

When in doubt, sit them out!

2. The coach is responsible for notifying the athlete's parents *if the athletic trainer is unavailable*
    a. Contact the parents to inform them of injury.
    b. In the event that an athlete's parents cannot be reached, and the athlete is able to be sent home (rather than transported directly to a medical facility):
        i. The coach should ensure that the athlete will be with a responsible individual, who is capable of monitoring the athlete and understanding home care instructions, before allowing the athlete to leave.
        ii. The coach should continue efforts to reach a parent.
        iii. Athletes with a suspected head injury should not be permitted to drive home.
    c. A coach or designated adult should remain with the student athlete until a parent arrives to insure the athlete's condition is being monitored.
3. If at an away competition where the ATC is not present, the coach should seek assistance from the host site certified athletic trainer or team physician for medical evaluation for the student athlete.

Follow-Up Care of the Athlete During the School Day
Concussion Management Team Responsibilities:

1. The athletic trainer will notify the concussion management team (AD, school nurse, counselor, teachers, head coach) when a concussion occurs.
2. The student athlete will be instructed to report to the ATC daily following concussion upon return to school. At that point, the ATC will:
    a. Re-evaluate the student athlete regularly using a graded symptom checklist.
    b. Provide an individualized health care plan based on both the athlete's current condition and initial injury information.
    c. Notify and update the concussion management team regarding necessary school accommodations (return to learn protocol).
    d. If a student athlete is not improving within a normative time frame, the ATC will contact the athlete's parents to discuss appropriate referral to concussion specialist/neuropsychologist.

Responsibilities of the Student's Counselor

1. Work with teachers to monitor the student athlete closely and recommend appropriate academic accommodations for students diagnosed with concussion.
2. Communicate with school nurse, athletic trainer, and teachers on a regular basis to provide the most effective care for the student.

Return to Academics Progression

1. When students have symptoms after a concussion, they may need a gradual return to their pre-injury academic load. This progression can speed recovery and support the student's return to a full academic load.
2. Parents will be advised to discuss specific academic accommodations with the student's physician and counselor.
3. The stages are flexible based on the student's tolerance to school activities.
4. Depending on symptoms, a student may start at any step and remain at each step as long as needed.
5. If symptoms worsen, the student should return to the previous step.
6. Daily check-ins with the student regarding how they are tolerating school is recommended.
7. Depending on symptoms, some students can begin supervised limited physical activity early after injury as prescribed by the ATC or physician.

*See chart on next page

CONCUSSION RETURN TO LEARN PROTOCOL

Updated August 2022

STAGE	KEY IDEAS	EXPECTED DURATION	ACADEMICS	RETURN TO SCHOOL
RED	Complete rest	2 - 4 days	No work to be done by student	- Rest - Do not attend school - Strict limits on computers, TV, texting, cell phones - No sports (JHS or club), band, PE, or other co-curricular/activity participation, including attendance at sporting events, retreats, or dances
ORANGE	- Significant deficits in processing and concentration - Slow integration back into activity	2 - 14 days	- In coordination with teachers and Academic VP, counselor will create two categories for work/assessment completion and develop a staggered work completion calendar 1) Excused (work excused but student responsible for information on assessments/final) 2) Responsible (work must be completed by student). Ideally, this category should make up no more than 50% of assignments or problems within assignments. - Make-up work to receive full credit - Support communication between home and school - Support student during slow recovery - access to teacher notes (if available); note: teacher is not responsible for re-teaching missed lessons - No tests or other assessments may be given during this time - Students eligible for Learning Ally account after 1 week in orange section. After 4 weeks in orange section, student may begin some assessment with consent of family, doctor, and administrator. Testing accommodations may include 1.5x extended time, split tests (ie. take tests in 3 parts over 3 days) or other best indicated accommodations.	- Attend school half-days (stagger classes throughout the week) - When you first return to class, don't take notes, just listen - Minimal use of screens; try to limit iPad use during class - Be patient with slow recovery and be involved in class as much as possible - Follow work completion calendar - Communicate with teachers on your progress of make-up work and recovery - No sports (JHS or club), band, chorus, or PE classes - No assemblies or other JHS activities, including attendance at sporting events, retreats, or dances
YELLOW	Gradual increase in student responsibilities as they progress to a normal workload	Longer stage, one week up to several months	- Access to academic accommodations dependent on student's recovery trajectory, vice-principal recommendation and medical input. - In coordination with teachers and Academic VP, counselor will create a staggered work completion calendar for make-up work and current work - Class Homework Absence Policy timeframes will not apply - Make up work to receive full credit - Continue to support communication between home and school with student/parent/guardian regularly - Student limited to one assessment per day to be coordinated by counselor and use Testing Center to schedule make up assessments as needed - Adjust work completion deadlines if symptoms worsen	- Attend school full days - Communicate with teachers on your progress of make-up work and recovery - Follow work completion calendar - No sports (JHS or club), band, chorus or PE classes - No assemblies or other JHS activities, including attendance at sporting events, retreats, or dances - If symptoms start to flare while you are in class, taking a 2-3 minute break in the Counseling Center may help - Complete as much homework as possible in 15-30 minute blocks of time, rather than all at once
GREEN	Cleared and complete return to normal activities		- Student no longer eligible for concussion related academic accommodations - Monitor completion of make up work	- Attend school full days - Continue to communicate with teachers regularly to make up school work - Return to sports/PE ONLY after the following: (1) written clearance by a physician; (2) completion of the return to play protocol; AND (3) you're managing your make up work and school work load

Return to Sport Progression

Stage	Objective	Exercise
Stage 1: No activity	Complete cognitive and physical rest until symptoms are improved**.** After the initially 24-72 hours of rest,	Initially NONE.

	athletes are advised to reinitiate sub-symptom threshold activities of daily living as tolerated.	*Sub symptom threshold exercise initiated and supervised by the ATC or physician ONLY.
Stage 2: Light aerobic exercise	Increase heart rate.	10-15 minutes light cardio and body weight strengthening
Stage 3: Sport Specific Exercise	Light to moderate aerobic conditioning, adding movement requiring more attention and coordination.	20-30 minutes moderate cardio with sport specific drills included. Increase strength training, keeping the weight light and repetitions high.
Stage 4: Non Contact	Moderately aggressive aerobic activity, progressing to training requiring high cognition and coordination.	Moderately aggressive cardio. Non-contact training drills. All forms of strength and agility training.
Stage 5: Full Contact	Restores the athletes confidence and allows assessment of functional skills.	Full unrestricted contact practice at game intensity.
Stage 6: Full Return to Competition		

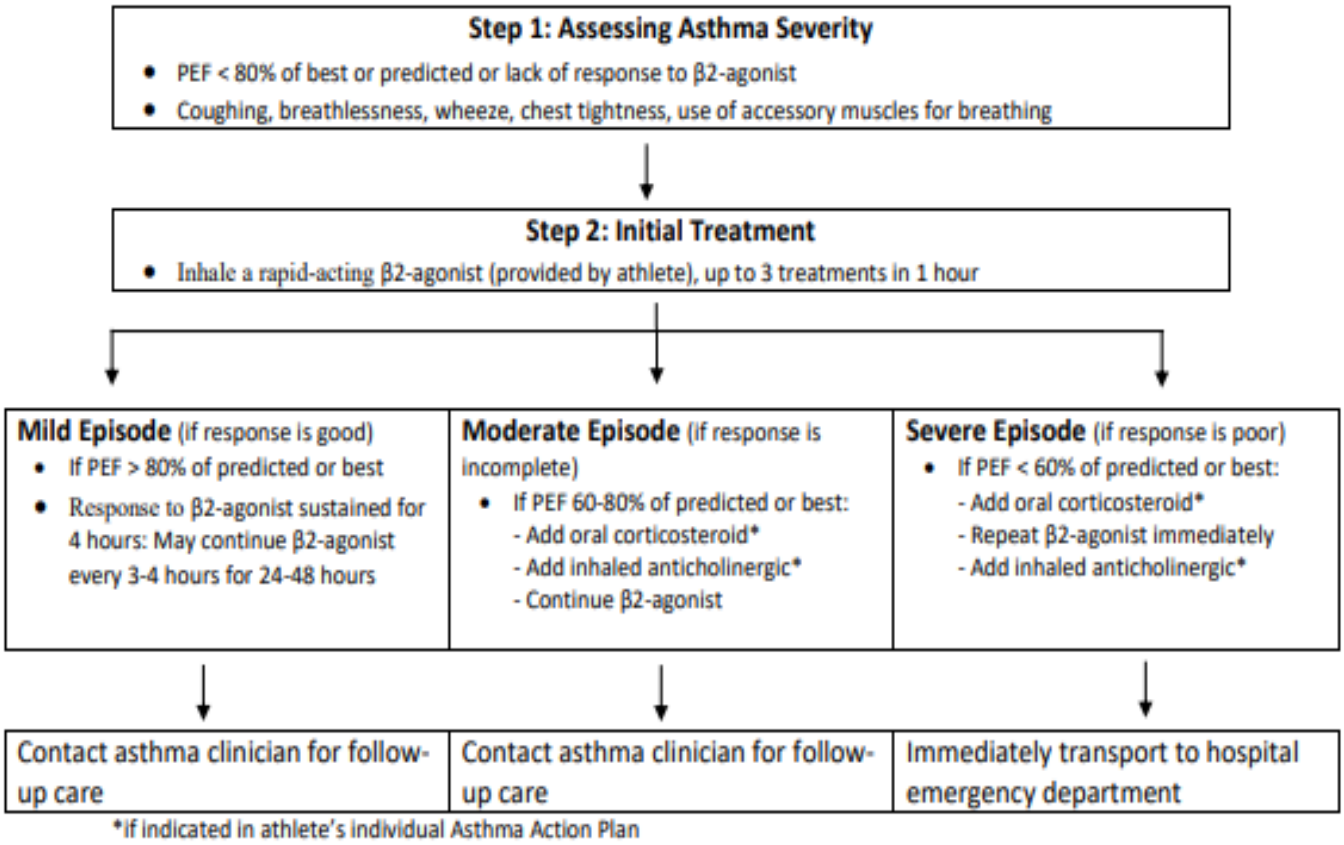
*If symptoms recur at any stage, stop activity. Once the athlete is symptom free for 24 hours they may return to previous asymptomatic stage.

1. An ATC may deem that a concussive injury has NOT occurred and return an athlete to play after a thorough evaluation and exertion test. If the ATC does not suspect concussion, they will discuss their findings with the coach and or student-athlete's parent/guardian before allowing the athlete to return to play.
2. If a student athlete is experiencing signs or symptoms of a concussion and continues to participate in activity, they are putting themselves at risk for further and greater injury, including but not limited to, second impact syndrome.
3. Student athletes must complete each stage of the graded return to play progression without the return of symptoms in order to be cleared for return to play. The ATC will have final say in return to play decisions and may take a more conservative approach if deemed necessary based on the student-athlete's progress.
4. An athlete may progress through the early stages of the graded return to play progression supervised by an ATC, but must have written clearance from a designated health care provider before initiating contact practice.
5. Baseline neurocognitive testing (Impact) will be performed prior to the start of a competitive season for the following sports: football, soccer, volleyball, wrestling, basketball, baseball, softball, lacrosse, pole vaulters. Post-concussion testing will be used as a decision-making tool in the return to play process.

Jesuit Sports Medicine Asthma Policy and Procedure

According to the National Athletic Trainers association, asthma is defined as a chronic inflammatory disorder of the airways characterized by variable airway obstruction and bronchial hyperresponsiveness. Signs and symptoms consistent with an asthmatic episode can include chest tightness, coughing, prolonged shortness of breath and wheezing. Breathing difficulties may be brought on by exposure to allergens, irritants, exercise or use of accessory muscles for breathing. Symptoms cane be especially aggravated with exposure to exercise and airborne allergens and pollutants.

Athletes diagnosed with asthma should keep their prescribed inhaler and/or a rescue inhaler with them during all athletic activities. The athlete should have an Asthma Action Plan on file with the school. In the event of an asthmatic episode, the sports medicine staff at Jesuit high school will monitor and provide necessary medical attention and care using the following guideline below.



*if indicated in athlete's individual Asthma Action Plan

JHS Diabetes Mellitus Policy

As with any student at Jesuit High School, students with Type 1 diabetes are encouraged to participate in athletics and other activities. In an effort to ensure a safe and enjoyable athletic experience, the sports medicine staff has adopted recommendations from the National Athletic Trainers' Association. To help prevent life-threatening events during exercise, and athletic competition. The first line of defense is the development of a Diabetes Care Plan from the athlete's physician. The Diabetes care plan should also be shared with and on file with the JHS Nurses.

This plan should identify blood glucose targets for practices and competitions with exclusion thresholds; strategies to prevent exercise-associated hypoglycemia, hyperglycemia, and ketosis; list of medications used for glycemic control; signs, symptoms, and treatment protocols for hypoglycemia, hyperglycemia, and ketosis; and emergency contact information. With regards to hypoglycemia, a three-pronged approach is used to help prevent this situation from occurring: frequent blood glucose monitoring, carbohydrate supplementation, and insulin adjustment.

The Athletic Trainer will carry a limited amount of carbohydrate supplements and will not supply insulin. It is the responsibility of the student-athlete to have appropriate carbohydrate supplements and other diabetic supplies with them at all practices and competitions. It is recommended that student-athletes check their blood glucose levels 2 or 3 times before, every 30 minutes during, and every hour up to 4 hours after physical activity. With regards to hyperglycemia, if insulin levels are adequate the student-athlete may still participate in their given activity. If insulin levels are insufficient, student-athletes may be required to check for ketones in their urine. If ketones are present, the student-athlete will not be allowed to participate in physical activity.