

Frederick Douglass High School



Emergency Action Plan

Jenne DeAngelis, LAT, ATC
Head Athletic Trainer
C: 859-300-1004
O: 859-381-3780



HealthCare

Orthopaedic Surgery
& Sports Medicine

Frederick Douglass High School Emergency Action Plan (EAP)

Address:

Frederick Douglass High School
2000 Winchester Road
Lexington, KY 40509

Emergency Personnel:

University of Kentucky Orthopaedics & Sports
Medicine (UKSM) Certified Athletic Trainers (ATC):

Jenne DeAngelis, LAT, ATC
859-300-1004

Cameron Gray, ATC
401-323-5899

Emergency Communication:

Locate UKSM ATC and/or KHSAA officials, along with FDHS staff personnel. The Athletic Trainer will attend to the injured athlete while a specified person calls EMS. If the Athletic Trainer is not on site when the injury occurs, the FDHS staff/coach will act as the “First Responder” and inform the Athletic Trainer when possible.

In the event of an emergency where an athlete is transported to the hospital, please make sure the following staff/administrators are notified:

1. Athletic Trainer
2. FDHS Principal, Lester Diaz
3. FDHS Athletic Director, Jeremy Dulaney
4. FCPS Athletic Director, Robbie Sayre

** In the event of a catastrophic incident, **school counselors** will be available to:

1. Provide availability for grief counseling to students
2. Provide follow up counseling post-incident for students

AED LOCATIONS (See map on page 7 for reference):

AED located in the main lobby of A wing

AED located in cafeteria

AED located outside gym in athletic wing

AED located in the field house in-between football field/softball field

***Portable AED located in the possession of the athletic trainer on duty during events.

PLAN FOR ACUTE CARE IN EMERGENCY SITUATIONS

Manage the immediate emergency care of the injured or ill **student-athlete only!**

1. Call 911 immediately!

- a. State your name, title, exact location, type of emergency, phone number, and be the last to hang up.

2. Locate Emergency Equipment

- a. A portable Automated External Defibrillator (AED) will be located where the Athletic Trainer is stationed. Other AED's will be located throughout the campus in specific locations; you will be directed to the closest one.

*****If an AED must be applied to someone on metal bleachers, please make sure no part of the AED pads are touching metal.**

3. Notify AD/AT/School Administrator/SRO

- a. Keep area clear/other athletes calm until help arrives.

4. Locate KHSAA pre-participation sports physical

- a. Provide EMS with current Physical Form.
EMS will require parental consent form, page 2 of KHSAA physical, to transport athlete when guardian is not present.
- b. Physicals are located with the coach AT ALL TIMES. Online copies are located on FDHS Google Drive. (Physicals should be current and up to date prior to competition)

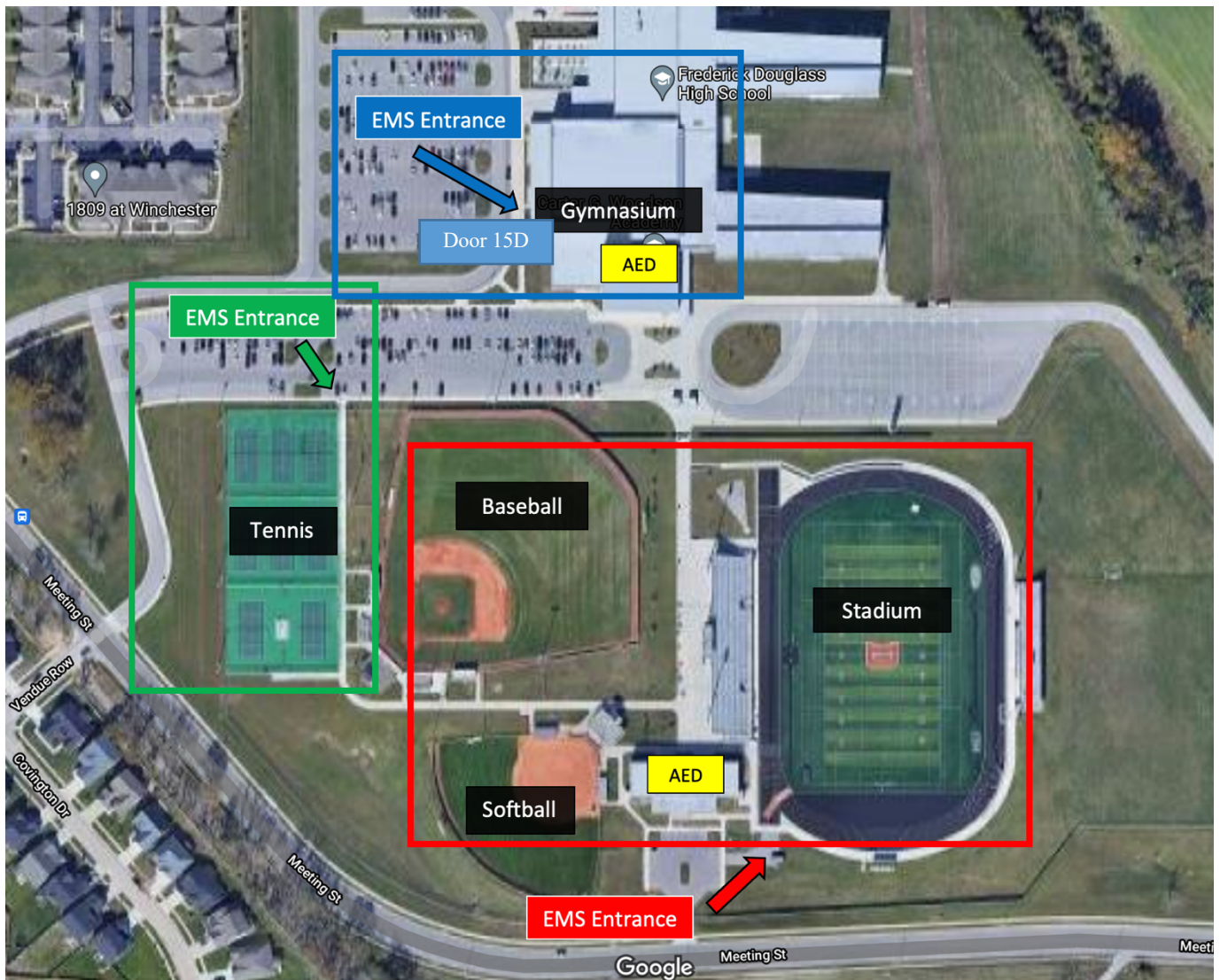
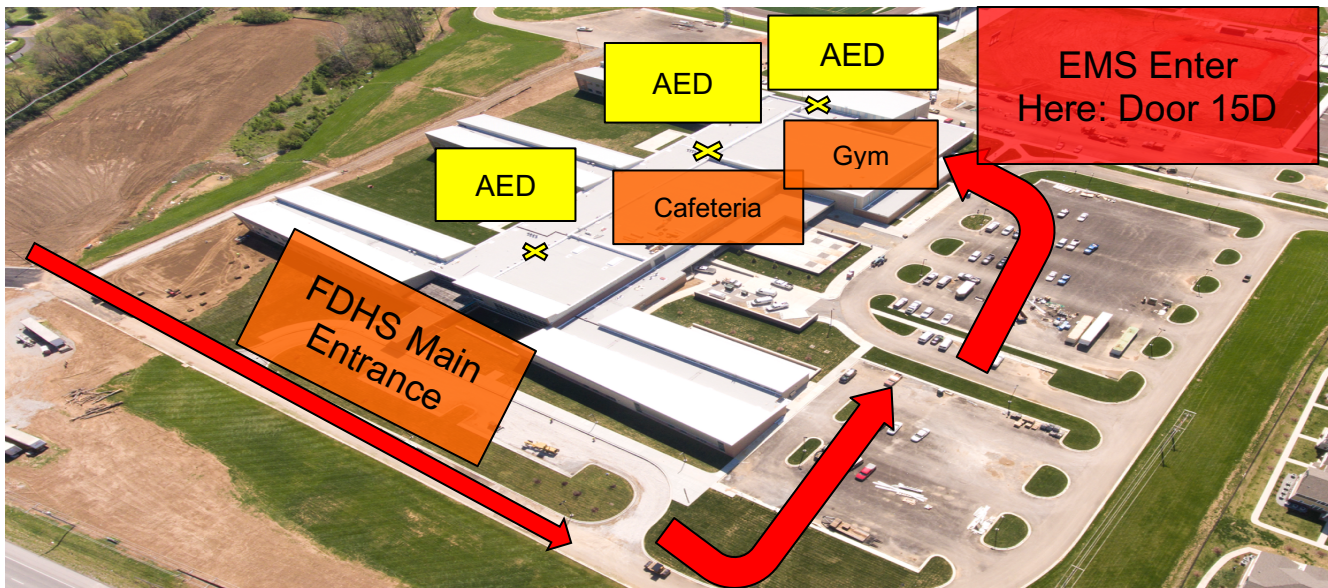
5. Upon arrival of EMS:

- a. Keep area clear of other athletes, spectators, etc...(have police assist if present). Ambulance will enter at the south end zone.
- b. Make sure gates/doors are open for EMS to get through.
***If located at the Athletic Complex, EMS will enter at the south end zone behind fieldhouse. If located in the Main Gym/Aux Gym EMS will enter through the side doors marked 15D.
THIS IS WHY WE DO NOT BLOCK THE GATES OR PARKING SPACES FOR FIELD ACCESS BEHIND THE FIELD HOUSE.
- c. Provide vital information to EMS (what happened, vital signs, treatment given thus far, etc...)
- d. Provide EMS with current Physical Form.
- e. Identify individual to go with the athlete to the hospital if parent/guardian is not available.

6. Follow-Up

- a. Call parents to check on athlete
- b. Call administrators to let them know the status of the athlete
- c. Document all events

Frederick Douglass High School Emergency Entrances



CONCUSSION MANAGEMENT PLAN

Students participating in KHSAA sanctioned sports at Frederick Douglass High School will follow the UK Sports Medicine mandatory return to play concussion protocol.

1. Any student athlete that exhibits signs, symptoms, or behaviors consistent with concussion will be removed from practice or competition and evaluated by the athletic trainer. The evaluation will consist of:
 - a. Symptom assessment
 - b. Physical and neurological exam
 - c. Cognitive assessment; balance exam
 - d. Clinical assessment for cervical spine trauma, skull fracture and intracranial bleed
2. A student athlete diagnosed with a concussion will be removed from practice or competition for the remainder of the calendar day.
3. The emergency action plan will be activated if an athlete is determined to have a concussion with any of the following signs and symptoms:
 - Prolonged loss of consciousness
 - Focal neurological deficit
 - Repetitive vomiting
 - Persistently diminished or worsening mental status
 - Spine injury
4. The student athlete will receive serial monitoring and evaluation for deterioration following injury. The student athlete's parent or guardian will be provided with instructions on care upon dismissal from activity.
5. Once a concussion has been diagnosed (or presumed by lack of examination by an appropriate health care provider), only an MD or DO can authorize return to play on a subsequent day, and such shall be in writing and provided to appropriate personnel.
6. Such approval should not be given unless a stepwise protocol has been observed by healthcare provider. (See below, Page 9)
7. It is highly recommended that each of these protocol steps be no less than twenty-four hours in length.
8. School administration shall then notify the coach as to the permission to return to practice or play.
9. If an event continues over multiple days, the designated physician has ultimate authority over return to play decisions. Such return to play decisions may not begin prior to the third day following the initial diagnosis or until the entire concussion protocol (see below) has been completed.

CONCUSSION RTP PROTOCOL:

Step 1	NO ACTIVITY (Symptom-free 24hrs)
Step 2	Light aerobic exercise
Step 3	Sport-specific exercise
Step 4	Non-contact training drills
Step 5	Full contact/competition practice
Step 6	Return to normal game play

***If athlete sees a PCP or other healthcare provider not associated with UKSM, a written note is REQUIRED to resume participation.

Personnel Roles and Responsibilities

Coach and/or KHSAA Official:

1. Remove any student athlete from practice or competition that shows signs of concussion after direct or indirect head trauma.
2. Ensure the student athlete is evaluated by the appropriate healthcare professional (athletic trainer).
3. Allow student athlete to return to play only after receiving medical clearance from the appropriate healthcare provider (athletic trainer).

Certified Athletic Trainer:

1. Remove any student athlete from practice or competition that shows signs of concussion after direct or indirect head trauma.
2. Perform a concussion evaluation and subsequent evaluations.
3. Provide home instructions to the parent or guardian.
4. Supervise activities during the return to play protocol including exertional tests.
5. Allow the student athlete to return to play after receiving clearance from appropriate physician.

Physician:

1. Direct the athletic trainer in caring for the student athlete.
2. Determine when the student athlete can return to play.

BLOOD-BORNE PATHOGENS AT ATHLETIC EVENTS

The purpose of this procedure is to assist the facility in eliminating or reducing the potential occupational exposure of employees to blood or other potentially infectious material. The following information is provided to eliminate or minimize occupational exposure to bloodborne pathogens in accordance with OSHA standard 29 *CFR* 1910.1030.

Bloodborne pathogens are infectious microorganisms present in blood that can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV), the virus that causes AIDS.

The CDC recommends **standard precautions** for the care of all patients, regardless of their diagnosis or presumed infection status.

Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources. This includes hand washing, appropriate personal protective equipment such as gloves, gowns, masks, whenever touching or exposure to patients' body fluids is anticipated. **Standard precautions must be** utilized when dealing with:

1. Blood
2. All body fluids, secretions, and excretions, ***except sweat***, regardless of whether or not they contain visible blood
3. Non-intact skin
4. Mucous membranes

The risk of blood-borne pathogen transmission at athletic events is directly associated with contact with blood or other body fluids. Athletic trainers who have responsibility for overseeing events at which such contact is possible should use appropriate preventive measures and be prepared to administer appropriate treatment, consistent with the requirements and restrictions of their jobs, and local, state, and federal law. In most cases, these measures will include:

1. Pre-event care and covering of existing wounds, cuts, and abrasions.
2. Provision of the necessary or usual equipment and supplies for compliance with universal precautions, including, for example, latex gloves, biohazard containers, disinfectants, antiseptics, and sharps containers (if necessary).
3. Early recognition and control of a bleeding athlete, including measures such as appropriate cleaning and covering procedures, or changing of blood-saturated clothes.
4. Requiring all athletes to report all wounds immediately.
5. Insistence that universal precaution guidelines be followed at all times in the management of acute blood exposure.
6. Appropriate cleaning and disposal policies and procedures for contaminated areas or equipment.
7. Appropriate policies with respect to the delivery of lifesaving techniques in the absence of protective equipment.
8. Post-event management including, as appropriate, reevaluation, coverage of wounds, cuts, and abrasions.
9. Appropriate policy development, including incorporation, with necessary legal and administrative assistance, of existing OSHA and other legal guidelines and conference or school rules and regulations.

LIGHTNING POSITON STATEMENT AND GUIDLINES

Activities WILL BE postponed or suspended if a thunderstorm appears imminent before or during activity.

WE WILL suspend activities for **30 minutes after a strike of lightning is seen AND/OR the sound of thunder is heard.**

***Any subsequent thunder or lightning after the beginning of the 30-minute count will reset the clock and another 30-minute count should begin.**

Per KHSAA, the Referee (Lead Official/Crew Chief) has authority once jurisdiction has begun as to suspensions and play resumption. The Referee (Lead Official/Crew Chief) shall stop play in a contest or scrimmage at the first sound of thunder or sight of lightning at the site and ensure adherence to this policy.

Active thunderstorms can pose an ongoing hazard to rescuers as well as spectators and sport participants. Rescuers and emergency personnel must ensure their own personal safety before venturing into the venue to provide aid. In the event of an emergency:

1. Activate EMS by calling 911!
2. Evaluate and treat patients in the following order:
 - a. Move patient(s) carefully to a safer location if needed.
 - b. Evaluate and treat for apnea (cessation of breathing), agonal breathing (gasping breaths) and cardiac arrest (absence of heartbeat).
 - c. Assess level of consciousness (can the patient respond to you or not).
 - d. Evaluate and treat for the possibility of spinal injuries (see above EAP, page 23).
3. Personnel responsible for the well-being of participants should maintain current cardiopulmonary resuscitation (CPR) and first-aid certifications.
4. If an automated external defibrillator (AED) is available, it should be applied on anyone who appears to be unconscious, pulseless or apneic. However, other first aid efforts and resuscitation should not be delayed while an AED is being located.

LIGHTNING POSTITON STATEMENT CONT...

- If thunder can be heard, lightning is close enough to be a hazard, and people should go to a safe location immediately.
- In the event of impending thunderstorms, those in control of outdoor events should fulfill their obligation to warn participants and guests of the lightning danger.
- All individuals have the right to vacate an outdoor site or unsafe area, without fear of repercussion or penalty, in order to seek a lightning-safe location if they feel in danger from impending lightning activity.

1. Establish a chain of command that identifies a specific person (or role) who is to make the decision to remove individuals from the field or activity. The following have recognized and unchallengeable authority to suspend activity:

1. Jenne DeAngelis
2. Jeremy Dulaney
3. Mike Harmon
4. Lead Official/Crew Chief

2. Use a reliable means of monitoring the local weather. Before the event, identify a specific person who is responsible for actively looking for threatening weather and is charged with notifying the chain of command.
3. Identify safe locations from the lightning hazard in advance of the event for each venue.
HOME TEAM – Will be directed to their designated locker room in the field house.
VISITING TEAM – Will be directed to designated locker rooms in the field house. Visiting team can also utilize the auxiliary gym inside the high school (if necessary).

*The field house building will be identified if impending storms are approaching, and participants will be informed of the access to those places during all outdoor activities.

4. Fully enclosed metal vehicles such as school buses, cars, and vans are also safe locations for evacuation.
5. Unsafe locations include most places with open areas, such as tents, dugouts, refreshment stands, gazebos, press boxes, and open garages are not safe from a lightning hazard.
6. Tall objects (trees, poles, towers, and elevated areas) are potential lightning targets and should be avoided. Large bodies of water, including swimming pools, are unsafe areas.

Any spectators will be notified of impending storms, and they must evacuate the athletic facility, per protocol. Spectators will be notified when they can safely re-enter.

HEAT RELATED EMERGENCIES AND HEAT INDEX POLICY

****Cold tanks will be located under the HOME bleachers on the FDHS turf field.**

****Ice machines are available in the both of the Athletic Training Rooms, as well as, the concession stands.**

EXERCISE ASSOCIATED MUSCLE CRAMPS:

Acute, painful, involuntary muscle contractions presenting during or after exercise. Contributing factors and conditions include dehydration, electrolyte imbalances, altered neuromuscular control, fatigue, or any combination of these factors.

Recovery: Minutes to hours

1. To relieve muscle spasms, the athlete should stop activity, replace lost fluids with sodium-containing fluids and begin mild stretching with massage of spasm.
2. A recumbent position (lying on either side, with body straight or bent/curled forward) may allow more rapid redistribution of blood flow to cramping leg muscles.

HEAT SYNCOPES:

Heat syncope, or orthostatic dizziness, often occurs in unfit or heat-unacclimated persons who stand for a long period of time in the heat or during sudden changes in posture in the heat.

Recovery: Occurs within hours

1. If an athlete experiences a brief episode of fainting associated with dizziness, tunnel vision, pale or sweaty skin, and a decreased pulse rate but has a normal rectal temperature (97F to 104F), then heat syncope is most likely the cause.
2. Move the athlete to a shaded area, monitor vital signs, elevate legs above the level of the head and rehydrate.

HEAT EXHAUSTION:

Heavy sweating/dehydration causing a decrease in venous return. Heat exhaustion is the inability to effectively exercise in the heat, secondary to a combination of factors that include cardiovascular insufficiency, hypotension, energy depletion, and central fatigue.

Recovery: Often occurs within 24 hrs. Same day return NOT ADVISED.

1. If feasible, measure body-core temperature (rectal temperature) and assess cognitive function and vital signs
2. If the athlete's temperature is elevated, remove his/her excess clothing to increase evaporative surface and to facilitate cooling.
3. Cool the athlete with fans, ice towels, or ice bags.
4. Remove the athlete to a cool or shaded environment if possible and start fluid replacement.
5. If athlete is not getting better, or begins to deteriorate, call 911 immediately!

HEAT STROKE:

Exertional heat stroke is the most severe heat illness!

High metabolic heat production and/or reduced heat dissipation leading to overwhelming response to the thermoregulatory system. It is characterized by neuropsychiatric impairment and a high core body temperature, typically 105 F.

Recovery: HIGHLY DEPENDANT on initial care/treatment. Further testing/medical clearance REQUIRED before allowed to return to play!

1. Measure rectal temperature, if feasible. Core body temp >104 degrees is a life threatening, medical emergency!!
2. Assess cognitive function and vital signs. If heat stroke is determined, ACTIVATE EMS IMMEDIATELY!!
3. Lower the body-core temperature as quickly as possible. The fastest way to decrease body temp is to remove clothes and equipment and immerse the body (trunk and extremities) into a pool/tub of cold water (35°F-59°F).
 **Aggressive cooling is the most critical factor in the treatment of exertional heat stroke. Circulation of the tub water may enhance cooling.
4. Monitor the temperature during cooling therapy and patient recovery every 5-10 minutes.
5. If the athlete's rectal temperature reaches approximately 101°F-102°F they should be removed from the pool or tub to avoid overcooling.
6. It is recommended that the athletes core body temperature drop below 104°F before he/she be transported by EMS.

KHSAA PROCEDURE FOR AVOIDING HEAT INJURY/ILLNESS

Gold standard for heat stress readings is the WetBulb Globe Temperature (WBGT).

WBGT is a measure of the heat stress in direct sunlight, which takes into account: temperature, humidity, wind speed, sun angle and cloud cover (solar radiation). **This differs from the heat index**, which takes into consideration the temperature and humidity and is calculated for shady areas. Heat index apps can still be used, just be aware of KHSAA heat guidelines. **Complete listing of support documents available at: <http://www.khsaa.org/sportsmedicine/>**

Under 95 degrees Heat Index OR WBGT 86.9 and BELOW

- * Provide ample amounts of water. This means that water should always be available and athletes should be able to take in as much water as they desire.
- * Optional water breaks every 30 minutes for 10 minutes in duration

95 degrees to 99 degrees Heat Index OR WBGT between 87 and 89.9

- * Provide ample amounts of water. This means that water should always be available and athletes should be able to take in as much water as they desire.
- * Mandatory water breaks every 30 minutes for 10 minutes in duration
- * Ice-down towels for cooling
- * Watch/monitor athletes carefully for necessary action.
- * Helmets and other possible equipment removed while not involved in contact.
- * Re-check Heat Index/WBGT every 30 minutes to monitor.

100 degrees to 104 degrees Heat Index OR WBGT between 90 and 91.9

- * Provide ample amounts of water. This means that water should always be available, and athletes should be able to take in as much water as they desire.
- * Mandatory water breaks every 30 minutes
- * Helmets and other possible equipment removed if not involved in contact or necessary for safety. If necessary for safety, suspend activity.
- * Ice tubs prepared in case of emergency
- * Reduce time of outside activity as well as indoor activity if air conditioning is unavailable.
- * Postpone practice to later in day.
- * Re-check Heat Index/WBGT every 30 minutes to monitor.

Above 104 degrees Heat Index OR WBGT OVER 92

- * All outside activities in practice and/or play **MUST BE SUSPENDED**

SUMMARY

Though scientific information and other alternative methods for determining Heat Index and participation restrictions are being studied, these initial steps should help ensure the health and safety of the participants in high school sports. Adherence to these guidelines represents a conscious effort by the interscholastic community to emphasize health and safety on a much higher level than any loss of competitive preparation. Any further revisions or enhancements will be distributed to the members of the KHSAA.

MENTAL HEALTH MANAGEMENT PLAN

The Sports Medicine staff at FDHS proposes the following management plan:

1. Evaluation and treatment of student-athletes with possible mental health concerns may be coordinated through FHDS school support services staff. The coach is often the first point of contact who will then contact the athletic trainer, school counselor, emergency room and/or parent/guardian to help coordinate care.
2. Diagnosis and management will be pursued using proper consulting services. Student-athletes who display any signs or symptoms or screen positive for multiple risk factors for mental illness may be referred to the FDHS School Counselor for psychological assessment and counseling services.
3. Athletic trainers, other student-athletes, coaches and other athletic department personnel should refrain from attempts to “counsel” a student-athlete that may be experiencing a mental health issue. However, they should encourage a student athlete to seek help from a properly trained mental health professional.
4. Student-athletes with certain mental health issues may not be cleared to participate in sports if sport participation is deemed detrimental to their treatment. During and after mental health evaluation and treatment, the mental health care provider will have unchallengeable authority regarding the student-athlete’s participation status. All return-to-play decisions will be made by the mental health care provider, athletic trainer, and the parent/guardian.
5. Student-athlete confidentiality regarding mental health issues will be maintained. However, all practitioners providing mental health care are required to report imminent risk to self and others, child and elder abuse, and court-ordered release of information as mandated by law.

A Mental Health Screening Questionnaire is part of the KHSAA pre-participation physical paperwork in addition to the student-athlete’s health history questionnaire. All mental health screening questionnaires will be scored according to recommended guidelines. Student-athletes who record scores that may indicate a possible mental health concern will be referred to the FDHS School Counselors for next steps in counseling services or assessments.

HIGH RISK Mental Health Management Plan:

1. Contact the student-athlete’s parent/legal guardian and clearly inform the parent/legal guardian of the risk to the student-athlete’s safety. Depending on the situation, you may need to request that the parent/legal guardian pick up the student athlete immediately and/or meet the student-athlete at the emergency room. Once a student-athlete has been released into the care of the parent/legal guardian, it may be recommended that the parent/legal guardian take the student-athlete for a mental health evaluation.
2. Contact the School Counselor to inform him/her regarding the emergency situation. The School Counselor will be available for consultation and follow-up. It should be noted that the School Counselor is NOT on-call outside of normal business hours. In the case of an emergency in the evening or on the weekend, athletic department personnel should notify the School Counselor of the situation by email and the School Counselor will respond no later than the next business day.
3. For cases in which the student poses an immediate risk of harm to him/herself or others, athletic department personnel should first address the risk to safety. To do so, the athletic department personnel may need to contact emergency services before informing the student-athlete’s parents of the situation or consulting with the School Counselor. In these extreme cases, athletic department personnel should also notify the Athletic Trainer and the Director of Athletics.

4. Parents/legal guardians should follow all recommendations from providers regarding ongoing treatment for the student-athlete and/or the student-athlete's ability to return to sport participation.
5. Return to sport participation following a mental health emergency will be determined by the Athletic Trainer and the Director of Athletics in conjunction with the mental health provider. The mental health provider will have unchallengeable authority over all return-to-play decisions.
6. If a student-athlete is given a prescription medication as part of their mental health care plan, it needs to be reported to the Athletic Trainer and School Counselor.
7. It is important that athletic department personnel help protect the student-athletes right to privacy. Athletic department personnel should exercise discretion regarding the sharing of information related to a student-athlete's mental health and, in many cases, will need only discuss such information with the student-athlete's parent/legal guardian, School Counselor, Athletic Trainer, and the Director of Athletics

Mental Health Referral Plan:

1. If athletic department personnel believe a student-athlete is exhibiting symptoms or behaviors concerning for a mental health issue, they should consult with the School Counselor. These behaviors are a cause for concern when they are a change from a student-athlete's normal lifestyle.
2. Athletic department personnel should communicate directly with the School Counselor if they witness or are aware of any of the following behaviors:
 - a. Thoughts of self-harm or suicidal intention
 - b. Thoughts of harming others or homicidal ideation
 - c. Acute psychosis (hallucinations, delusions)
 - d. Acute delirium or state of confusion
 - e. Severe Paranoia
 - f. Multiple depressive symptoms
 - g. Depressive symptoms that persist for several weeks and/or lead to destructive behavior
 - h. Alcohol and drug abuse as an attempt to self-treat
 - i. Overtraining or burnout
3. The school counselor may recommend that a student-athlete who is exhibiting signs or symptoms of a mental health issue be referred for therapeutic evaluation and treatment. In such cases, the school counselor will make this recommendation to the student-athlete's parent/legal guardian. The parent/legal guardian will then have the responsibility of following the recommendation. The school counselor may provide a list of therapeutic resources by request of the student-athlete or the student-athlete's parent/legal guardian.
4. If a student-athlete is given a prescription medication as part of their mental health care plan, it needs to be reported to the Athletic Trainer and School Counselor.
5. Parents/legal guardians should follow all recommendations from providers regarding ongoing treatment for the student-athlete and/or the student-athlete's ability to continue sport participation.
6. Ideally, the student-athlete and the student-athlete's parent/legal guardian will work with the School Counselor and Athletic Trainer to ensure the student-athlete's overall mental health and ability to participate in sports is continuously monitored to ensure compliance to care.

FREDERICK DOUGLASS HIGH SCHOOL MENTAL HEALTH SUPPORT SERVICES STAFF

The FDHS support staff members are great resources to help collaborate and connect students, families, and staff when social, emotional, mental health concerns or crises arise. ANY professional would be glad to partner. However, directing concerns to respective academy counselors or admin is preferable to start via email or call. Please use this contact list as a point of reference as needed.

The S.T.O.P. TIP LINE can be used to report bullying, violence, or other school issues anonymously or to be contacted. <https://safeschools.ky.gov/> and is shared with a team of school level staff to review/follow-up

****For an EMERGENCY after hours call Lexington Police (859.258.3600) or 911****

Mr. Lester Diaz, *Executive Principal*, Ext. 52005

Mr. Michel Stead, *School Social Worker*, Ext. 52263

Mrs. Sharrion Brown, *District Mental Health Counselor*, Ext. 52008

Mr. Michael Allen, MSW, Youth Services Coordinator, Ext. 52180

Mrs. Bryony Rowe, *School Psychologist*, Ext. 52141

	<i>School Counselor</i>	<i>Administrator</i>
FRESHMAN ACADEMY	Mrs. Julie Cron Ext. 52011	Mr. Aldan Meade Ext. 52009
HEALTH SCIENCE	Mrs. Erin Cope Ext. 52156	Mrs. Jamie Mills Ext. 52122
BIOMED MAGNET	Ms. Wendi Rogers Ext. 52156*	Mrs. Jamie Mills Ext. 52122
PROFESSIONAL SERVICES	Mr. Antonio Melton Ext. 52010	Mr. Michael Harmon Ext. 52219
TECHNOLOGY	Mr. Derrick Thomas Ext. 52012	Mr. Alan Mayes Ext. 52212
CARTER G. WOODSON	Mr. Ronaldo Johnson Ext. 40102	Mrs. Janaye Boeteng Ext. 40107

COMMUNITY & NATIONAL HOTLINES

National Domestic Violence Hotline – 1-800-799-7233

National Suicide Prevention Hotline – 1-800-273-8500

Suicide Crisis Text – Text **Help** to 741741

Trevor Project Crisis Line for LGBTYQ+ Youth – 1-866-488-7386

Arbor Youth Services – 859-245-2501

Salvation Army Homeless Shelter – 859-252-7706

FCPS Mental Health Resource Page: <https://www.fcps.net/mental>

SICKLE CELL TRAIT AND EMERGENCY MANAGEMENT

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

We recommend confirming sickle cell trait status in all athletes’ preparticipation physical examinations. As all 50 states screen at birth, this marker is a base element of personal health information that should be made readily available to the athlete, the athlete’s parents, and the athlete’s healthcare provider, including those providers responsible for determination of medical eligibility for participation in sports.

Important Facts:

1. Sickle cells can “logjam” blood vessels and lead to collapse from ischemic rhabdomyolysis, the rapid breakdown of muscles starved of blood.
2. Sickling can begin in 2-3 minutes of any all-out exertion – and can reach grave levels soon thereafter if the athlete continues to struggle.
3. Heat, dehydration, altitude, and asthma can increase the risk for and worsen sickling, even when exercise is not all-out.
4. Collapse from exertional sickling in athletes is under-recognized and often misdiagnosed. Sickling collapse is a medical emergency.
5. There is no contraindication to participation in sport for the athlete with sickle cell trait.
6. Red blood cells can sickle during intense exertion, blocking blood vessels and posing a grave risk for athletes with sickle cell trait.
7. Screening and simple precautions may prevent deaths and help athletes with sickle cell trait thrive in their sport.

SICKLING COLLAPSE EMERGENCY ACTION PLAN

In the event of a sickling collapse, treat it as a medical emergency by doing the following:

1. **Call 9-1-1 and explain the situation.**
2. **Check vital signs.**
3. **If available, administer high-flow oxygen, 15 LPM, with a non-rebreather face mask.**
4. **Cool the athlete, if necessary.**
5. **If vital signs diminish, attach an AED, begin CPR – Sickling collapse is a life-threatening emergency.**
6. **Tell the doctors to expect explosive rhabdomyolysis and grave metabolic complications.**

SICKLE CELL FACTS

Sickling VS. Heat Cramping

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

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

Precautions and Treatment

No sickle-trait athlete is ever disqualified, because simple precautions seem to suffice. For the athlete with sickle cell trait, the following guidelines should be adhered to:

1. Build up slowly in training with paced progressions, allowing longer periods of rest and recovery between repetitions.
2. Encourage participation in preseason strength and conditioning programs to enhance the preparedness of athletes for performance testing which should be sport specific. Athletes with sickle cell trait should be excluded from participation in performance tests such as mile runs, serial sprints, etc., as several deaths have occurred from participation in this setting.
3. Cessation of activity with onset of symptoms [muscle ‘cramping’, pain, swelling, weakness, tenderness; inability to “catch breath”, fatigue].
4. If sickle-trait athletes can set their own pace, they seem to do fine.
5. All athletes should participate in a year-round, strength and conditioning program that is consistent with individual needs, goals, abilities and sport-specific demands.
6. Athletes with sickle cell trait who perform repetitive high-speed sprints and/or interval training that induces high levels of lactic acid should be allowed extended recovery between repetitions since this type of conditioning poses special risk to these athletes.
7. Ambient heat stress, dehydration, asthma, illness, and altitude predispose the athlete with sickle trait to an onset of crisis in physical exertion. These athletes should be instructed to do the following:
 - a. Adjust work/rest cycles for environmental heat stress
 - b. Emphasize hydration
 - c. Control asthma
 - d. Do not work out if an athlete with sickle trait is ill
 - e. Watch closely the athlete with sickle cell trait who is new to altitude
 - f. Modify training and have supplemental oxygen available for competitions
8. Educate to create an environment that encourages athletes with sickle cell trait to report any symptoms immediately; any signs or symptoms such as fatigue, difficulty breathing, leg or low back pain, or leg or low back cramping in an athlete with sickle cell trait should be assumed to be sickling

DIABETIC EMERGENCY ACTION PLAN

Trauma, even in persons without diabetes, often causes a hyperglycemic state; thus, for athletes with type 1 diabetes, an individualized plan established for use during injury recovery, including frequency of blood glucose monitoring.

Hypoglycemia (Low blood sugar) is when your blood sugar levels have fallen low enough that you need to take action to bring them back to your target range. This is usually when your blood sugar is less than 70 mg/dL.

Hyperglycemia is the technical term for high blood glucose (blood sugar). High blood sugar happens when the body has too little insulin or when the body can't use insulin properly.

Normal fasting blood glucose levels are 60 to 100 mg/dL
Normal levels, up to 2 hours after a meal, are < 140 mg/dL

Diabetes care plan should include the following:

1. Blood glucose monitoring guidelines. Address frequency of monitoring and pre-exercise exclusion values.
2. Insulin therapy guidelines. Should include:
 - a. Type of insulin used
 - b. Dosages and adjustment strategies for planned activities
 - c. Insulin correction dosages for high blood glucose levels
3. List of other medications. Include those used to assist with glycemic control and/or to treat other diabetes- related conditions.
4. Guidelines for hypoglycemia recognition and treatment.
Include prevention, signs, symptoms, and treatment of hypoglycemia, including instructions on the use of glucagon.
5. Guidelines for hyperglycemia recognition and treatment. Include prevention, signs, symptoms, and treatment of hyperglycemia and ketosis.
6. Emergency contact information. This should include:
 - a. Parents' and/or other family member's telephone numbers
 - b. Physician's telephone number, and
 - c. Consent for medical treatment (for minors).

Athletic Training Preventative Measures

Supplies to treat diabetes-related emergencies should be available at all practices and games. The athlete (or athlete's parents/guardians, in the case of minors) provides the following items:

1. A copy of the diabetes care plan.
2. Blood glucose monitoring equipment and supplies.
(The athletic trainer should check the expiration dates of supplies, such as blood glucose testing strips and insulin, on a regular basis. Blood glucose testing strips have a code number located on the outside of the test strip vial. The code number on the blood glucose meter and test strip vial must match).
3. Supplies to treat hypoglycemia, including sugary foods (glucose tablets, sugar packets) or sugary fluids (orange juice, non-diet soda) and/or a glucagon injection kit.
4. Supplies for urine or blood ketone testing.
5. Spare batteries (for blood glucose meter and/or insulin pump) and, if applicable, spare infusion sets and reservoirs for insulin pumps.

Recognition, Treatment, and Prevention of HYPOGLYCEMIA

10. Strategies to recognize, treat, and prevent hypoglycemia typically include blood glucose monitoring, carbohydrate supplementation, and/or insulin adjustments. Athletes with diabetes should discuss with their physician's specific carbohydrate qualities and quantities as well as the use of an insulin reduction plan for activity.
11. Athletic trainers should know the signs, symptoms, and treatment guidelines for mild and severe hypoglycemia. Hypoglycemia is defined as mild if the athlete is conscious and able to swallow and follow directions or severe if the athlete is unable to swallow, follow directions, or eat as directed or is unconscious. Treatment of severe hypoglycemia requires a glucagon injection, and athletic trainers should be trained in mixing and administering glucagon. The athlete, athlete's family, or physician can provide appropriate training.

Recognition, Treatment, and Prevention of HYPERGLYCEMIA

1. Athletes with type 1 diabetes and athletic trainers are advised to follow the American Diabetes Association (ADA) guidelines for avoiding exercise during periods of hyperglycemia.
2. Athletes with type 1 diabetes who experience hyperglycemia during short-term, intense, and stressful periods of exercise should consult with their physicians concerning an increased basal rate or the use of small insulin boluses to counteract this phenomenon.
12. Athletes should drink non-carbonated fluids when blood glucose levels exceed the renal glucose threshold (180 mg/dL, or 10 mmol/L), which may lead to increased urination, fluid loss, and dehydration.

Insulin Administration

1. Insulin should be administered into the subcutaneous tissue. The abdomen, upper thigh, and upper arms are common sites for injection. Intramuscular injections of insulin should always be avoided as muscle contractions may accelerate insulin absorption.
2. Depending on the type of insulin used by the athlete, heat and cold should be avoided for 1 to 3 hours after an injection of rapid-acting insulin (eg, lispro, aspart, or glulisine) and up to 4 hours for fast-acting (eg, regular) insulin.
3. Heat may increase insulin absorption rates. Thus, athletes with type 1 diabetes should avoid warm whirlpools, saunas, showers, hot tubs, and baths after injection.
13. Cold may decrease insulin absorption rates. Therefore, athletes with type 1 diabetes should avoid using ice and cold sprays directly over the injection or infusion site after insulin administration. Similarly, cold whirlpools should be avoided after insulin injection.
14. Insulin pump users should replace insulin infusion sets every 2 to 3 days to reduce skin and infusion site irritation.
15. Extreme ambient temperature (<36F or >86F) can reduce insulin action. Athletes with type 1 diabetes are advised to check blood glucose levels frequently and replace the entire insulin-filled cartridge and infusion set if any signs of unusual hyperglycemia occur in extreme environmental conditions.

SPINAL CORD INJURY TREATMENT GUIDELINES

Activate EMS by calling 911 and locate the Athletic Trainer!

Any athlete suspected of having a spinal injury (paralysis, numbness/tingling of arms or legs, cervical spine pain) **SHOULD NOT BE MOVED.**

- IF YOU ARE UNSURE, the event should be managed as though a spinal injury exists!
 - The athlete's airway, breathing, circulation, neurological status and level of consciousness should be assessed by the certified athletic trainer, coach and/or first responder. The **ONLY** reason an athlete would need to be moved is if there is an obstruction to airway, breathing and/or circulation.
1. Make sure the call to 911 has been placed and the AED has been located in the event of respiratory arrest.
 2. The athlete should be placed in a supine position (on their back) while maintaining spinal immobilization (it is preferred that immobilization be held by the certified athletic trainer, team physician, or emergency responder).
 3. Do not allow other players or other unauthorized persons to move a teammate who is lying immobile unless they are in IMMEDIATE DANGER.
 4. Whoever assumes c-spine/head immobilization is the team leader when moving and spine boarding.

OFF-CAMPUS SPORTING EVENTS

Instructions for Off-Campus Sports:
(Golf, Swimming, Bowling, Cross Country, Bass Fishing)

1. When arriving at off-campus site, check to see if site has AED. If so, know location of AED.
2. Check for location of land telephone line. Cell phones may be used for emergency contact if needed. Cell phones need to be assessed for signal and full charge.
3. Know location of safe shelter in case you need to evacuate due to inclement weather.