PREAMBLE
The National Athletic Trainers’ Association Code of Ethics states the principles of ethical behavior that should be followed in the practice of athletic training. It is intended to establish and maintain high standards and professionalism for the athletic training profession.

The principles do not cover every situation encountered by the practicing athletic trainer, but are representative of the spirit with which athletic trainers should make decisions. The principles are written generally; the circumstances of a situation will determine the interpretation and application of a given principle and of the Code as a whole. When a conflict exists between the Code and the law, the law prevails.

PRINCIPLE 1:
Members shall respect the rights, welfare and dignity of all.
1.1 Members shall not discriminate against any legally protected class.
1.2 Members shall be committed to providing competent care.
1.3 Members shall preserve the confidentiality of privileged information and shall not release such information to a third party not involved in the patient’s care without a release unless required by law.

PRINCIPLE 2:
Members shall comply with the laws and regulations governing the practice of athletic training.
2.1 Members shall comply with applicable local, state, and federal laws and institutional guidelines.
2.2 Members shall be familiar with and abide by all National Athletic Trainers’ Association standards, rules and regulations.
2.3 Members shall report illegal or unethical practices related to athletic training to the appropriate person or authority.
2.4 Members shall avoid substance abuse and, when necessary, seek rehabilitation for chemical dependency.

PRINCIPLE 3:
Members shall maintain and promote high standards in their provision of services.
3.1 Members shall not misrepresent, either directly or indirectly, their skills,
training, professional credentials, identity or services.
3.2 Members shall provide only those services for which they are qualified through
education or experience and which are allowed by their practice acts and other pertinent
regulation.
3.3 Members shall provide services, make referrals, and seek compensation only
for those services that are necessary.
3.4 Members shall recognize the need for continuing education and participate in
educational activities that enhance their skills and knowledge.
3.5 Members shall educate those whom they supervise in the practice of athletic
training about the Code of Ethics and stress the importance of adherence.
3.6 Members who are researchers or educators should maintain and promote
ethical conduct in research and educational activities.

PRINCIPLE 4:
Members shall not engage in conduct that could be construed as a conflict of interest or
that reflects negatively on the profession.
4.1 Members should conduct themselves personally and professionally in a manner that
does not compromise their professional responsibilities or the practice of athletic training.
4.2 National Athletic Trainers’ Association current or past volunteer leaders shall
not use the NATA logo in the endorsement of products or services or exploit
their affiliation with the NATA in a manner that reflects badly upon the profession.
4.3 Members shall not place financial gain above the patient’s welfare and shall not
participate in any arrangement that exploits the patient.
4.4 Members shall not, through direct or indirect means, use information obtained in the
course of the practice of athletic training to try to influence the score or outcome of an
athletic event, or attempt to induce financial gain through
gambling.
ALFRED UNIVERSITY
DIVISION OF ATHLETIC TRAINING

Philosophy and Mission

The mission of the Athletic Training Program (ATP) at Alfred University is to provide the student with knowledge, standards, behavior models, code of ethics, and skills needed as an Athletic Trainer. The professional program is based on a solid foundation in the college of professional studies arena, with a strong emphasis in biological and anatomical science.

The student, while pursuing a degree in Athletic Training, shall develop proficiency in the following performance domains as determined by the National Athletic Trainers’ Association Board of Certification (NATABOC):

1. Prevention
2. Recognition, evaluation, and assessment
3. Immediate care
4. Treatment, rehabilitation, and reconditioning
5. Organization and administration
6. Professional development and responsibility

The ATP is based on the philosophy that education is a life-long process. This is particularly true for a profession, which through its practice of specific skills, seeks to fill the needs of athletes and recreationally active individuals. The needs of this select group are dynamic due to continually improving methods of training and new findings through research. Therefore, the formal phase of professional education cannot hope to produce a fully and perpetually qualified practitioner. It must seek to thoroughly educate the students in these concepts, principles, and tools, which are particularly applicable to the continued acquisition of knowledge and perfection of skills in the field of athletic training.

The program provides interested students the opportunity of concentrated study and clinical work experiences. Upon successful completion of the ATP, the student will receive a Bachelor of Science degree in Athletic Training, thus making the student eligible to sit for the National Athletic Trainers’ Association Board of Certification exam. Upon passing the NATABOC exam, the student will attain the qualification of a Certified Athletic Trainer.

GOALS OF THE ATP PROGRAM ARE AS FOLLOWS:

1. Provide a quality, up-to-date educational curriculum.
2. Provide leadership and service to the university community through continuing education.
3. Promote self-directed learning and critical thinking as desirable professional behavior.
4. Encourage participation in the National Athletic Trainers’ Association, New York State Athletic Trainers’ Association, Eastern Athletic Trainers’ Association, and other professional organizations, that will further enhance the students’ educational opportunities.
5. Provide the educational means of developing knowledge in Cognitive, Affective and Psychomotor domains and Clinical Proficiencies.
Telephone Directory

Ambulance/Police/Fire                     9-911 (On Campus)
                                        911 (On Campus)
Poison Control Center                    1-800-492-2414
Police                                   (607)587-8877
Ambulance                                (607)587-8880
AU Security                              (607) 871-2108
AU Student Health Services               (607) 871-2400
AU Athletics Fax                         (607) 871-2712
AU Counseling and Student Development Center (607) 871-2300
Allegany County Crisis Hotline           (585) 593-5706
AU Division of Athletic Training         (607) 871-2891

Athletic Training Staff

Daniel Curtin, MD                        Team Physician/General Medicine
                                        · Office: (585)728-2044
                                        · Cell: (607)382-1141

Chris Yartym, MS, ATC                    Program Director
                                        · Office: (607)871-2902
                                        · Cell: (607)776-4728

Andrea Wilkinson MS, ATC                 Clinical Education Coordinator
                                        · Office: (607)871-2738
                                        · Cell: (330) 204-7581

Jessica S. Hurlbut MS, ATC               Head Athletic Trainer
                                        · Office: (607)871-2916
                                        · Cell: (315) 430-8865
                                        · Home: (585)466-3281

Doug Graham MS, ATC                      Assistant Athletic Trainer
                                        · Office: (607)871-3495
                                        · Cell: (585) 610-8258

Joshua Long MS, ATC                      Assistant Athletic Trainer
                                        · Office: (607)871-2738
                                        · Cell: (440)479-2639

St. James Mercy Hospital                 (607) 324-8000
                                        · General Information
                                        · Emergency Room (607) 324-8890
                                        · Urgent Care Center (607) 324-8100
                                        · Patient Billing (607) 324-8030
                                        · X-ray (607) 324-8252
Physician Disclaimer Statement
(Supervision of Athletic Training Staff)

I, Dr. Daniel Curtin, agree to bear the responsibility of overseeing and directing the total care of all the athletes, that participate in the Alfred University intercollegiate athletic program. All Certified Athletic Trainers will work under my guidance and supervision at all times. Alfred University Certified Athletic Trainers will be given flexibility to work within the professional standards set forth by the National Athletic Trainers’ Association as well as the state practice acts outlined by the New York State Education Department. I am committed to serving as an advisor to the Certified Athletic Training Staff and as a health care provider to those athletes that participate in NCAA sponsored sports at Alfred University. Let it be known that I possess the absolute authority in determining the eligibility and playing status of an athlete who desires to participate in any of the intercollegiate sports offered by Alfred University. Ultimately, I am responsible for the legal liability and actions of the Certified Athletic Trainers.

_______________________________________
Dr. Daniel Curtin, Team Physician

_______________________________________
Jessica S. Hurlbut, MS, ATC, Head Athletic Trainer

_______________________________________
Paul Vecchio, Director of Athletics
EMERGENCY PLAN: ALFRED STATE COLLEGE TRACK

Venue Directions: Enter the campus by turning at the light onto Alfred State Campus. Make a right at the end of the road and follow it to the Orvis parking lot. Go to the end of that parking lot and you will find the Alfred State Track.

GPS Coordinates (in the event of the need for a medical helicopter transport): 42.255182, 77.794731. This spot marks center of Pioneer Field as most accessible location for landing.

Intercollegiate Team Utilization: Men’s and Women’s Track & Field and Cross Country (Practices & Meets)

Emergency Communication:

<table>
<thead>
<tr>
<th></th>
<th>Fixed Telephone Line</th>
<th>607-587-4359</th>
</tr>
</thead>
<tbody>
<tr>
<td>Athletic Training Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Security Phone</td>
<td></td>
<td>Located near track</td>
</tr>
<tr>
<td>Certified Athletic Trainer</td>
<td>Mobile Phone</td>
<td>Ask certified athletic trainer on site for practice</td>
</tr>
<tr>
<td>Athletic Director</td>
<td>Paul Vecchio</td>
<td>871-2193</td>
</tr>
<tr>
<td>Team Physician</td>
<td>Daniel Curtin, MD</td>
<td>585-728-2070</td>
</tr>
</tbody>
</table>

Emergency Personnel: certified athletic trainer and athletic training student(s) on site for practice; additional sports medicine staff is accessible from the Alfred State athletic training facility (adjacent to Track)

Emergency Equipment: Emergency equipment (AED, trauma kit, vacuum splints, and spine board) located on a motorized cart parked on sidelines during practice; additional emergency equipment located within the athletic training facility

Roles of First Responders:
1. Immediate care of the injured or ill student-athlete
2. Emergency equipment retrieval
3. Activation of emergency medical system (EMS)
   1. call EMS from land line; athletic trainer’s cellular phone; security phone
   2. *call 9-911 (provide name, address, telephone number, number of individuals injured, condition of injured, first aid treatment, specific directions, other information as requested)
   3. campus police/security (if on site) will assist in coordinating as necessary
4. Directing EMS to scene
   1. open appropriate gates/doors
   2. designate individuals to “flag down” EMS and direct to scene
   3. scene control: limit scene to first aid providers and move bystanders away from area
Venue Map:

1. Agriculture Science Bldg. (AGRLAB)
2. Allied Health Bldg. (ALHLTH)
3. Anderson Complex (HORTIC)
4. Athletic Fields
5. Braddon Hall
6. Burdick Hall
7. Central Dining Hall
8. Document Center
9. EJ Brown Hall (BRWNHL)
10. Engineering Technology Bldg.
11. Facilities Services
12. Getman Hall
13. Heating Plant
<table>
<thead>
<tr>
<th>Number</th>
<th>Building Name</th>
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</thead>
<tbody>
<tr>
<td>14</td>
<td>Hinkle Memorial Library</td>
</tr>
<tr>
<td>15</td>
<td>Hunter Student Development Ctr.</td>
</tr>
<tr>
<td>16</td>
<td>Huntington Administration Bldg.</td>
</tr>
<tr>
<td>17</td>
<td>MacKenzie Complex</td>
</tr>
<tr>
<td>18</td>
<td>The Main Attraction</td>
</tr>
<tr>
<td>19</td>
<td>Main Gate A</td>
</tr>
<tr>
<td>20</td>
<td>Main Gate B</td>
</tr>
<tr>
<td>21</td>
<td>Orvis Activities Center (STUACT)</td>
</tr>
<tr>
<td>22</td>
<td>Peet Hall</td>
</tr>
<tr>
<td>23</td>
<td>Pioneer Center</td>
</tr>
<tr>
<td>24</td>
<td>Robinson/Champlin Hall</td>
</tr>
<tr>
<td>25</td>
<td>Shults Hall</td>
</tr>
<tr>
<td>26</td>
<td>St. Jude's Center</td>
</tr>
<tr>
<td>27</td>
<td>TA Parish Hall</td>
</tr>
<tr>
<td>28</td>
<td>Townhouses</td>
</tr>
<tr>
<td>29</td>
<td>Van Hall Alumni House</td>
</tr>
<tr>
<td>30</td>
<td>Victorian House (University Police)</td>
</tr>
</tbody>
</table>
Alfred University  
College of Professional Studies  
Division of Athletic Training  

EMERGENCY PLAN: DAVIS GYM  

Venue Directions: Davis Gym is located on the North end of the campus beside Main Street (Rt. 12). Turn onto Alfred University Campus at the light and Davis front entrance is on the left or turn left to McLane parking lot for the back entrance.

GPS Coordinates (in the event of the need for a medical helicopter transport): 42.259924,-77.785014.  
This spot marks center of Merrill Field as most accessible location for landing.

Intercollegiate Team Utilization: Men’s & Women’s Track & Field and Cross Country (practices)

Emergency Communication:

<table>
<thead>
<tr>
<th></th>
<th>Fixed Telephone Line</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Athletic Training Room</td>
<td></td>
<td>871-2891</td>
</tr>
<tr>
<td>Davis Gym</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Security Phone</td>
<td>Call Out Telephone Line</td>
<td>Path from Merrill Field to the McLane Center</td>
</tr>
<tr>
<td>Certified Athletic Trainer</td>
<td>Mobile Phone</td>
<td>Ask certified athletic trainer on site for practice</td>
</tr>
<tr>
<td>Athletic Director</td>
<td>Paul Vecchio</td>
<td>871-2193</td>
</tr>
<tr>
<td>Team Physician</td>
<td>Daniel Curtin, MD</td>
<td>585-728-2070</td>
</tr>
</tbody>
</table>

Emergency Personnel: sports medicine staff is accessible from the McLane Center athletic training facility (adjacent to Davis Gym)

Emergency Equipment: Emergency equipment (AED, trauma kit, vacuum splints, and spine board) and additional emergency equipment located within the athletic training facility in the McLane Center

Roles of First Responders:
1. Immediate care of the injured or ill student-athlete
2. Emergency equipment retrieval
3. Activation of emergency medical system (EMS)  
   1. call EMS from Davis Gym land line; athletic trainer’s cellular phone; security phone *call 9-911 (provide name, address, telephone number, number of individuals injured, condition of injured, first aid treatment, specific directions, other information as requested)
   2. campus police/security (if on site) will assist in coordinating as necessary
4. Directing EMS to scene  
   1. open appropriate gates/doors  
   2. designate individuals to “flag down” EMS and direct to scene  
   3. scene control: limit scene to first aid providers and move bystanders away from area
EMERGENCY PLAN: HORNELL HIGH SCHOOL SOFTBALL FIELD

Venue Directions: Hornell High School’s Softball Field is located next to Route 36. An access road off Route 36 leads to the Hornell High School parking lot and access to the softball field.

GPS Coordinates (in the event of the need for a medical helicopter transport): 42.200261,-77.394540.
This spot marks center of Hornell High School as most accessible location for landing.

Intercollegiate Team Utilization: Softball (Practices & Games)

Emergency Communication:

<table>
<thead>
<tr>
<th></th>
<th>Pay Telephone Line</th>
<th>Hornell High School Lobby</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lobby Pay Phone</td>
<td>Pay Telephone Line</td>
<td>Ask certified athletic trainer on site for practice</td>
</tr>
<tr>
<td>Certified Athletic Trainer</td>
<td>Mobile Phone</td>
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<tr>
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<td>Daniel Curtin, MD</td>
<td>585-728-2070</td>
</tr>
</tbody>
</table>

Emergency Personnel: certified athletic trainer and athletic training student(s) on site for practice

Emergency Equipment: Emergency equipment (AED, trauma kit, vacuum splints, and spine board)

Roles of First Responders:
1. Immediate care of the injured or ill student-athlete
2. Emergency equipment retrieval
3. Activation of emergency medical system (EMS)
   1. call EMS from pay phone; athlete’s cellular phone; security phone
      *call 9-911 (provide name, address, telephone number, number of individuals injured, condition of injured, first aid treatment, specific directions, other information as requested)
   2. campus police/security (if on site) will assist in coordinating as necessary
4. Directing EMS to scene
   1. open appropriate gates/doors
   2. designate individuals to “flag down” EMS and direct to scene
   3. scene control: limit scene to first aid providers and move bystanders away from area
EMERGENCY PLAN: JERICHO FIELD

Venue Directions: Jericho Hill practice field is located 1 mile south of campus off Route 12. An access road off Kenyon Road (directly off Route 12) gives access to Jericho Hill practice field.

GPS Coordinates (in the event of the need for a medical helicopter transport): 42.228288, -77.800659. This spot marks center of Jericho Hill Club Sport practice field as most accessible location for landing.

Intercollegiate Team Utilization: Football (Practices)  
Men’ and Women’s Soccer (Practices)

Emergency Communication:

<table>
<thead>
<tr>
<th>Certified Athletic Trainer</th>
<th>Mobile Phone</th>
<th>Ask certified athletic trainer on site for practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Athletic Director</td>
<td>Paul Vecchio</td>
<td>871-2193</td>
</tr>
<tr>
<td>Team Physician</td>
<td>Daniel Curtin, MD</td>
<td>585-728-2070</td>
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</tbody>
</table>

Emergency Personnel: certified athletic trainer and athletic training student(s) on site for practice; additional sports medicine staff is accessible from the McLane Center athletic training facility (back on AU campus)

Emergency Equipment: Emergency equipment (AED, trauma kit, vacuum splints, and spine board) located on sidelines during practice; additional emergency equipment located within the athletic training facility in the McLane Center

Roles of First Responders:
1. Immediate care of the injured or ill student-athlete
2. Emergency equipment retrieval
3. Activation of emergency medical system (EMS)
   1. call EMS from athletic trainer’s cellular phone
   *call 9-911 (provide name, address, telephone number, number of individuals injured, condition of injured, first aid treatment, specific directions, other information as requested)
   2. campus police/security (if on site) will assist in coordinating as necessary
4. Directing EMS to scene
   1. open appropriate gates/doors
   2. designate individuals to “flag down” EMS and direct to scene
   3. scene control: limit scene to first aid providers and move bystanders away from area
Venue Map

- Jericho Practice Field
- Club Sport Practice Field

Alfred University  Kenyon Rd.

Route 12 Wellsville
EMERGENCY PLAN: MCLANE GYMNASIUM

Venue Directions: McLane Center is located on the north end of campus beside Main Street (Rt. 12). Turn into the north entrance at the stop light then make a left into the McLane Center parking lot. Drive all the way to the back of the parking lot and enter through the back doors of the gymnasium.

GPS Coordinates (in the event of the need for a medical helicopter transport): 42.259924,-77.785014. This spot marks center of Merrill Field as most accessible location for landing.

Intercollegiate Team Utilization: Men’s & Women’s Basketball (Games & Practices)
Volleyball (Games & Practices)
Men’s & Women’s Lacrosse (Practices)
Softball (Practices)
Men’s Tennis (Practices)

Emergency Communication:

<table>
<thead>
<tr>
<th>Athletic Training Room</th>
<th>Fixed Telephone Line</th>
<th>871-2891</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merrill Field</td>
<td>Fixed Telephone Line</td>
<td>871-2236; Located Press Box of Merrill Field</td>
</tr>
<tr>
<td>Security Phone</td>
<td>Call Out Telephone Line</td>
<td>Path from Merrill Field to the McLane Center</td>
</tr>
<tr>
<td>Certified Athletic Trainer</td>
<td>Mobile Phone</td>
<td>Ask certified athletic trainer on site for practice</td>
</tr>
<tr>
<td>Athletic Director</td>
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<td>871-2193</td>
</tr>
<tr>
<td>Team Physician</td>
<td>Daniel Curtin, MD</td>
<td>585-728-2070</td>
</tr>
</tbody>
</table>

Emergency Personnel: certified athletic trainer and athletic training student(s) on site for practice and games; additional sports medicine staff is accessible from the athletic training facility (just outside of the gymnasium and lower entrance to McLane).

Emergency Equipment: Emergency equipment (AED, trauma kit, vacuum splints, crutch kit, and spine board) located in the athletic training facility during practice and games; additional emergency equipment located within the athletic training facility.

Roles of First Responders:
1. Immediate care of the injured or ill student-athlete
2. Emergency equipment retrieval
3. Activation of emergency medical system (EMS)
   1. call EMS from athletic training facility; athletic trainer’s cellular phone
      *call 9-911 (provide name, address, telephone number, number of individuals injured, condition of injured, first aid treatment, specific directions, other information as requested)
   2. campus police/security (if on site) will assist in coordinating as necessary
4. Directing EMS to scene
   1. open appropriate gates/doors
2. designate individuals to “flag down” EMS and direct to scene
3. scene control: limit scene to first aid providers and move bystanders away from area
Alfred University Athletic Training Policies and Procedures Handbook

EMERGENCY PLAN: MERRILL FIELD

Venue Directions: Merrill Field is located on the North end of the campus beside Main Street (Rt. 12). An access road directly off Main Street is the most direct route to Merrill Field.

GPS Coordinates (in the event of the need for a medical helicopter transport): 42.259924, -77.785014. This spot marks center of Merrill Field as most accessible location for landing.

Intercollegiate Team Utilization:
- Football (Practices & Games)
- Men’s and Women’s Soccer (Practices & Games)
- Men’s and Women’s Lacrosse (Practices & Games)

Emergency Communication:

<table>
<thead>
<tr>
<th></th>
<th>Fixed Telephone Line</th>
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</thead>
<tbody>
<tr>
<td>Athletic Training Room</td>
<td>871-2891</td>
<td></td>
</tr>
<tr>
<td>Merrill Field</td>
<td>871-2236; Located Press Box of Merrill Field</td>
<td></td>
</tr>
<tr>
<td>Security Phone</td>
<td>Path from Merrill Field to the McLane Center</td>
<td></td>
</tr>
<tr>
<td>Certified Athletic Trainer</td>
<td>Ask certified athletic trainer on site for practice</td>
<td></td>
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<tr>
<td>Team Physician</td>
<td>Daniel Curtin, MD</td>
<td>585-728-2070</td>
</tr>
</tbody>
</table>

Emergency Personnel: certified athletic trainer and athletic training student(s) on site for practice; additional sports medicine staff is accessible from the McLane Center athletic training facility (adjacent to Merrill Field)

Emergency Equipment: Emergency equipment (AED, trauma kit, vacuum splints, and spine board) located on a motorized cart parked on sidelines during practice; additional emergency equipment located within the athletic training facility in the McLane Center

Roles of First Responders:
1. Immediate care of the injured or ill student-athlete
2. Emergency equipment retrieval
3. Activation of emergency medical system (EMS)
   1. call EMS from press box; athletic trainer’s cellular phone; security phone
      *call 9-911 (provide name, address, telephone number, number of individuals injured, condition of injured, first aid treatment, specific directions, other information as requested)
   2. campus police/security (if on site) will assist in coordinating as necessary
4. Directing EMS to scene
   1. open appropriate gates/doors
   2. designate individuals to “flag down” EMS and direct to scene
   3. scene control: limit scene to first aid providers and move bystanders away from area
Venue Map
Alfred University  
College of Professional Studies  
Division of Athletic Training  

EMERGENCY PLAN: MCLA NE NATITORIUM  

Venue Directions: McLane Center is located on the North end of the campus beside Main Street (Rt. 12) An access road directly off Main Street gives access to the front entrance. The pool is located to the right after you enter through the doors.  

GPS Coordinates (in the event of the need for a medical helicopter transport): 42.259924,-77.785014.  This spot marks center of Merrill Field as most accessible location for landing.  

Intercollegiate Team Utilization: Men’s and Women’s Swimming (Practices & Meets)  

Emergency Communication:  

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<th>Athletic Training Room</th>
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</tr>
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<tbody>
<tr>
<td>Certified Athletic Trainer</td>
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</tr>
<tr>
<td>Team Physician</td>
<td>Daniel Curtin, MD</td>
<td>585-728-2070</td>
</tr>
</tbody>
</table>

Emergency Personnel: certified athletic trainer and athletic training student(s) on site for practice and meets; additional sports medicine staff is accessible from the McLane Center athletic training facility (bottom floor of McLane)  

Emergency Equipment: Emergency equipment (AED, trauma kit, vacuum splints, and spine board) located in the athletic training room during practice and meets; additional emergency equipment located within the athletic training facility in the McLane Center  

Roles of First Responders:  

1. Immediate care of the injured or ill student-athlete  
2. Emergency equipment retrieval  
3. Activation of emergency medical system (EMS)  
   1. call EMS from athletic training room; athletic trainer’s cellular phone; security phone  
   *call 9-911 (provide name, address, telephone number, number of individuals injured, condition of injured, first aid treatment, specific directions, other information as requested)  
   2. campus police/security (if on site) will assist in coordinating as necessary  
4. Directing EMS to scene  
   1. open appropriate gates/doors  
   2. designate individuals to “flag down” EMS and direct to scene  
   3. scene control: limit scene to first aid providers and move bystanders away from area
Alfred University  
College of Professional Studies  
Division of Athletic Training

EMERGENCY PLAN: HARRINGTON SOFTBALL FIELD

Venue Directions: Softball Field is located on the north end of the campus along Main Street.

- **From the South:** From intersection of Pine Street and Mains head northeast on North Main St toward Greene St. Go .3 miles and turn right into Merrill Field entrance. Harrington Field is 236 feet on the right.
- **From the North:** From intersection of NY State Route 21 and NY State Route 244 head west on NY-244 W toward Sherman Rd. Go 1.6 miles and turn left into Merrill Field entrance. Harrington Field is 236 feet on the right.

GPS Coordinates (in the event of the need for a medical helicopter transport): 42.259924,-77.785014. This spot marks center of Merrill Field as most accessible location for landing.

Intercollegiate Team Utilization: Harrington Softball Field (practices & games)

Emergency Communication:

<table>
<thead>
<tr>
<th>Athletic Training Room</th>
<th>Fixed Telephone Line</th>
<th>871-2891</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merrill Field</td>
<td>Fixed Telephone Line</td>
<td>871-2236; Located Press Box of Merrill Field</td>
</tr>
<tr>
<td>Security Phone</td>
<td>Call Out Telephone Line</td>
<td>Path from Merrill Field to the McLane Center</td>
</tr>
<tr>
<td>Certified Athletic Trainer</td>
<td>Mobile Phone</td>
<td>Ask certified athletic trainer on site for practice</td>
</tr>
<tr>
<td>Athletic Director</td>
<td>Paul Vecchio</td>
<td>871-2193</td>
</tr>
<tr>
<td>Team Physician</td>
<td>Daniel Curtin, MD</td>
<td>585-728-2070</td>
</tr>
</tbody>
</table>

Emergency Personnel: certified athletic trainer and athletic training student(s) on site for practice; additional sports medicine staff is accessible from the McLane Center athletic training facility (adjacent to Harrington Softball Field)

Emergency Equipment: Emergency equipment (AED, trauma kit, vacuum splints, and spine board) located on a motorized cart parked on sidelines during practice; additional emergency equipment located within the athletic training facility in the McLane Center

Roles of First Responders:

1. Immediate care of the injured or ill student-athlete
2. Emergency equipment retrieval
3. Activation of emergency medical system (EMS)
   1. call EMS from press box; athletic trainer’s cellular phone; security phone
   2. call 9-911 (provide name, address, telephone number, number of individuals injured, condition of injured, first aid treatment, specific directions, other information as requested)
   3. campus police/security (if on site) will assist in coordinating as necessary
4. Directing EMS to scene
   1. open appropriate gates/doors
2. designate individuals to “flag down” EMS and direct to scene
3. scene control: limit scene to first aid providers and move bystanders away from area
EMERGENCY PLAN: MCLA NE TENNIS COURTS

Venue Directions: The tennis courts are located on the North end of the campus beside Main Street (Rt. 12). Turn into the Alfred University Campus at the stop light and make a left into the McLane parking lot. Go to the very end of the lot where the tennis courts are located.

GPS Coordinates (in the event of the need for a medical helicopter transport): 42.259924,-77.785014. This spot marks center of Merrill Field as most accessible location for landing.

Intercollegiate Team Utilization: Men’s and Women’s Tennis (Practices & Games)

Emergency Communication:

<table>
<thead>
<tr>
<th>Athletic Training Room</th>
<th>Fixed Telephone Line</th>
<th>871-2891</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merrill Field</td>
<td>Fixed Telephone Line</td>
<td>871-2236; Located Press Box of Merrill Field</td>
</tr>
<tr>
<td>Security Phone</td>
<td>Call Out Telephone Line</td>
<td>Path from Merrill Field to the McLane Center</td>
</tr>
<tr>
<td>Certified Athletic Trainer</td>
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</tr>
<tr>
<td>Team Physician</td>
<td>Daniel Curtin, MD</td>
<td>585-728-2070</td>
</tr>
</tbody>
</table>

Emergency Personnel: certified athletic trainer and athletic training student(s) on site for matches; additional sports medicine staff is accessible from the McLane Center athletic training facility (adjacent to Harrington Softball Field)

Emergency Equipment: Emergency equipment (AED, trauma kit, vacuum splints, and spine board) located on a motorized cart parked on Merrill field or sidelines during matches; additional emergency equipment located within the athletic training facility in the McLane Center

Roles of First Responders:
1. Immediate care of the injured or ill student-athlete
2. Emergency equipment retrieval
3. Activation of emergency medical system (EMS)
   1. call EMS from athletic training room; athletic trainer’s cellular phone; security phone
      *call 9-911 (provide name, address, telephone number, number of individuals injured, condition of injured, first aid treatment, specific directions, other information as requested)
   2. campus police/security (if on site) will assist in coordinating as necessary
4. Directing EMS to scene
   1. open appropriate gates/doors
   2. designate individuals to “flag down” EMS and direct to scene
   3. scene control: limit scene to first aid providers and move bystanders away from area
Venue Map
EMERGENCY DIRECTIONS

EMERGENCY DIRECTIONS TO MCLANE CENTER / TENNIS COURTS:

☐ **LOCATION** – east of downtown Alfred on the campus of Alfred University; adjacent to Davis Gymnasium, Franklin W. Olin Building, and Merrill Field;

☐ **PREFERRED ENTRANCE TO BASKETBALL / VOLLEYBALL ARENA** – off Rt. 244; left at stop light; take first left; proceed down driveway to back of building on left; go through 2 sets of double doors; once through doors turn right and proceed straight to the gymnasium

☐ **ALTERNATE ENTRANCE #1 TO BASKETBALL/VOLLEYBALL ARENA** – Northeast side of the building; proceed through the parking lot and bear left at end of building; proceed through brown metal doors to the gymnasium

☐ **ALTERNATE ENTRANCE #2 TO BASKETBALL / VOLLEYBALL ARENA** – small circular driveway in front of building on Rt. 244; enter through sets of double doors; proceed straight ahead to open stairway; down the stairs and turn right; proceed straight to double doors on right at court level

☐ **PREFERRED ENTRANCE TO ATHLETIC TRAINING ROOM / WEIGHTROOM**
  - Athletic Training Room – off Rt. 244; left at stop light; take first left; proceed down driveway to back of building on left; go through 2 sets of double doors; once through double doors proceed straight ahead across the hall to door marked “Athletic Training Room”
  - Weight Room - off Rt. 244; left at stop light; take first left; proceed down driveway to back of building on left; go through 2 sets of double doors; once through double doors turn left and then right; straight down long hallway; at end of hall turn right; weight room is located on the left between large windows

☐ **ALTERNATE ENTRANCE TO ATHLETIC TRAINING ROOM / WEIGHT ROOM**
  - Athletic Training Room – small circular driveway in front of building on Rt. 244; enter through sets of double doors; proceed straight ahead to open stairway; down the stairs and turn left; take another left down long hallway; turn left at the end of the hallway and the Athletic Training Room is the first door on the left;
  - Weight Room – small circular driveway in front of building on Rt. 244; enter through sets of double doors; proceed straight ahead to open stairway; down the stairs; proceed straight ahead down the hallway; weight room is located between large windows

☐ **PREFERRED ENTRANCE TO TENNIS COURTS** – proceed along driveway and through parking lot behind McLane Center to the end of parking lot; tennis courts are located down small hill on north end of parking lot.

☐ **ALTERNATE ENTRANCE TO TENNIS COURTS** – small circular driveway in front of building on Rt. 244; enter through sets of double doors; proceed straight ahead to open stairway; down the stairs and turn right; proceed straight to double doors on right at basketball court level; proceed across the gymnasium and out double brown doors to the parking lot; proceed across the parking lot to tennis courts located on the left at the base of small hill;
EMERGENCY DIRECTIONS TO DAVIS GYMNASIUM:

☐ LOCATION – east of downtown Alfred on the campus of Alfred University; adjacent to Franklin W. Olin Building, Scholes Library, Harder Hall, and Merrill Field

☐ PREFERRED ENTRANCE TO INDOOR TRACK / GYMNASIUM ARENA – off Rt. 244; left at stop light; take first left; proceed down driveway to first entrance/parking area on the right; turn into parking area; go through doors to track/gymnasium arena

☐ ALTERNATE ENTRANCE TO INDOOR TRACK / GYMNASIUM ARENA – off Rt. 244; left at stop light; proceed straight to first building on the left; go through double doors in front of building leading to track/gymnasium arena

EMERGENCY DIRECTIONS TO MERRILL FIELD/SOFTBALL FIELD

☐ LOCATION – east of downtown Alfred on the campus of Alfred University; adjacent to BINS MERRIL:

☐ PREFERRED ENTRANCE TO FOOTBALL/SOCCER/LACROSSE ARENA – off Rt. 244; left at first Alfred University sign; proceed down driveway to back of bleachers region; once at the bleachers either proceed to Merrill field or softball field

☐ ALTERNATE ENTRANCE TO FOOTBALL/SOCCER/LACROSSE ARENA – off Rt. 244; left at stop light; take first left; proceed down driveway far end of parking area; proceed down pathway to either softball field or Merrill field
EMERGENCY PLAN

The following emergency plan is a general outline for the Alfred University Athletic Department. Specific emergency plans for each individual sport detailing emergency phone numbers, entrances and access routes, emergency phone locations, etc. are on file in the athletic training room.

EMERGENCY COMMUNICATION HAND SIGNALS

- "touch body part" indicates the injured body part
- "raised fist / number 1" ATC/MD is needed on the field
- "scuba OK (pat top of head)" ATC is not needed on field
- "overhead circular" activate EMS immediately
- "baseball safe signal" spineboard/stretcher is needed on the field
- "hand pumping motion" splints are needed on the field
- "steering wheel motion / number 4" cart/motorized transportation is needed on field
- "number 2" two people needed to assist transport

EMERGENCY ALGORITHMS

Cardiorespiratory\textsuperscript{i}, Medical\textsuperscript{ii}, and/or Orthopedic\textsuperscript{iii} Emergency occurring at a PRACTICE SESSION

1. AU staff athletic trainer will evaluate the athlete, administer basic life support (BLS), and stabilize the athlete until EMS arrives.
2. The athletic training student or an assistant coach will use the cellular phone to call EMS (if no land line or cellular phone is available, the designated individual will proceed to the nearest campus emergency phone or pay phone to access EMS).
3. An assistant coach, the head coach, or athletic training student will proceed to wait at the field entrance and guide EMS on to the field.
4. The athletic training student will assist the AU certified athletic trainer as necessary.

Cardiorespiratory\textsuperscript{i}, Medical\textsuperscript{ii}, and/or Orthopedic\textsuperscript{iii} Emergency occurring at a HOME GAME

1. The AU staff athletic trainer will proceed onto the field to evaluate the athlete.
2. The staff athletic trainer and athletic training student will provide BLS and stabilize the athlete until EMS arrives.
3. The athletic training student or an assistant coach will use the cellular phone to call EMS (if no land line or cellular phone is available, the designated individual will proceed to the nearest campus emergency phone or pay phone to access EMS).
4. An assistant coach, the head coach, or athletic training student will proceed to wait at the field entrance and guide EMS on to the field.
5. The athletic training student will assist the AU certified athletic trainer as necessary.
Cardiorespiratory, Medical, and/or Orthopedic Emergency occurring at an AWAY GAME

1. The AU staff athletic trainer (if available) will proceed onto the field, evaluate the athlete, administer BLS, and stabilize the athlete until EMS arrives.

2. The athletic training student will notify the host certified athletic training that an emergency exists and that EMS is needed.

3. The host certified athletic trainer and the athletic training student will continue to administer BLS and stabilize the athlete as best possible while following the host institution’s emergency protocols.

4. The athletic training student (if an AU staff athletic trainer is present) or an assistant coach will accompany the injured athlete to the hospital with the injured athlete’s emergency medical information card.

Once at the hospital, the athletic training student or assistant coach will immediately call an AU staff athletic trainer (if applicable) to notify him/her of the emergency situation.

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1 Cardiorespiratory emergency includes, but is not limited to: cardiac arrest, respiratory arrest, foreign body airway obstruction (FBAO), pneumothorax, sucking chest wound, and flail chest.

1 Medical emergency includes, but is not limited to: anaphylactic shock, hypovolemic shock, internal bleeding, head injury, diabetic emergencies (insulin shock, diabetic coma), seizure disorder, and asthma.

1 Orthopedic emergency includes, but is not limited to: cervical spine injury, flail chest, femur fracture, hip dislocation, and knee/ankle dislocation.

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Conclusion

The importance of being properly prepared when athletic emergencies arise cannot be stressed enough. An athlete’s survival may hinge on how well trained and prepared athletic healthcare providers are. It is prudent to invest athletic department ownership in the emergency plan by involving the athletic administration and sport coaches as well as sports medicine team. The emergency plan should be reviewed at least once a year with all athletic personnel, along with CPR and first aid refresher training. Though development and implementation of the emergency plan, the athletic association helps ensure that athletes will have the best care provided when an emergency situation does arise.

---

Approved by _______________________________________                             ___________________

Team Physician                                                                                       Date

Approved by _______________________________________                             ___________________

Head Athletic Trainer                                                                              Date
CATASTROPHIC INJURY PLAN / PHONE TREE

In the event of a catastrophic injury that occurs during an NCAA sponsored athletic event, a series of steps and contacts need to be completed to successfully manage the situation. All certified athletic trainers, athletic training students, athletic department personnel, and university administrators should be familiar with the catastrophic injury plan.

For the purposes of this policy, a catastrophic injury is defined by the NCAA as the death of a student-athlete, coach, or staff member from any cause, or a disabling and/or quality of life altering injury. Initiation of the Catastrophic Injury Plan is secondary to providing care for the injured individual. Care providers may delegate notification of the Head Athletic Trainer.

Implementation of Catastrophic Injury Plan/Individual Roles

Head Coach:
- If a catastrophic injury occurs when an AU Athletic Trainer is not present, the coach should notify the Head Athletic Trainer who will initiate the Catastrophic Injury plan. The coach should appoint a staff person to remain with the injured individual until relieved by a university administrator. The role of this person is to act as a university representative and to coordinate communication on the status of the injured individual.
- The coach will coordinate communication with the team regarding the injured individual’s status once information can be released.

Team Physician:
- If not present at athletic event, contacted by Head Athletic Trainer
- Contacts Athletic Director
- If present at athletic event, accompanies injured individual to nearest medical facility and directs care as able based on circumstances
- If not present at athletic event, directs care as able based on circumstances

Head Athletic Trainer:
- Initiates Catastrophic Injury plan
- Contacts Team Physician if not present at athletic event
- Contacts Assistant Athletic Trainers and Graduate Assistant Athletic Trainer
- Contacts university insurance carrier
- Contacts NCAA Catastrophic Injury insurance carrier
- Coordinates communication amongst the medical staff regarding the status of the injured individual
- Ensures all Alfred University personnel and students involved in care of injured individual provide a written account of the event at the earliest possible time
  - Accounts will be sent back to Head Athletic Trainer via certified mail to provide an accurate date stamp of reports
- Contacts parents if not present at athletic event
Director of Athletics:
- Contacted by Team Physician
- Contacts Dean of Students
- Contacts Sports Information Director; relays information to be released to public
- Communicates needs of Department of Athletics to Dean of Students
- Conducts a debriefing session with all involved parties

Vice President of Student Affairs:
- Contacted by Dean of Students
- Contacts President
- Contacts Risk Management
- Contacts Legal Counsel

Dean of Students:
- Contacted by Director of Athletics
- Contacts Vice President of Student Affairs
- Contacts Emergency Response Team
- Determines which university administrator(s) will be main contact with athlete and/or family and communicates this to the Head Athletic Trainer
- Coordinates needs of Department of Athletics with the Emergency Response Team
  - Primary needs will most likely be counseling support (CSDC and Interfaith Advisor)

Assistant Athletic Trainer/Graduate Assistant:
- If not present at athletic event, contacted by Head Athletic Trainer
- If present at athletic event, contacts Head Athletic Trainer
- Duties as assigned by Team Physician and Head Athletic Trainer

Sports Information Director (SID):
- Contacted by Director of Athletics
- Contacts Director of Communications
- Releases information as permitted based on medical confidentiality and the wishes of the injured individual’s family
- Establishes contact information with hospital providing medical treatment/services
- Information will be communicated to SID via the Director of Athletics

President:
- Contacted by Vice President of Student Affairs

Risk Management:
- Contacted by Vice President of Student Affairs
- Duties consistent with reporting a catastrophic injury

Legal Counsel:
- Contacted by Vice President of Student Affairs
- Duties consistent with occurrence of a catastrophic injury
Phone Tree

1. Team Physician – Daniel Curtin, MD
   - Office – 585-728-2070
   - Cell – 607-382-1141

2. Head Athletic Trainer – Jessica S. Hurlbut, MS, ATC
   - Office – 607-871-2783
   - Cell – 315-430-8865
   - Home – 585-466-3281

3. Director of Athletics – Paul Vecchio
   - Office – 607-871-2193
   - Cell – 607-481-9830

4. Vice President of Student Affairs – Kathy Woughter
   - Office – 607-871-2132
   - Cell – 607-368-8276

5. Dean of Students – Norm Pollard
   - Office – 607-871-2132
   - Home – 607-587-8625
   - Cell – 607-368-2127

6. Assistant Athletic Trainer – Douglas Graham, MS, ATC
   - Office – 607-871-3495
   - Cell – 585-610-8258

7. Assistant Athletic Trainer – Josh Long MS, ATC
   - Office – 607-871-2738
   - Cell – 440-479-2639

8. Graduate Assistant Athletic Trainer – Britney Potter, ATC
   - Office – 607-871-2031
   - Cell – 908-433-2410

9. Graduate Assistant Athletic Trainer- Andrea Telesca, ATC
   - Office – 607-871-2031
   - Cell – 585-489-4969

10. Risk Management – Judith Green
    - Office – 607-871-2966
    - Cell – 607-382-9077

11. Director of Counseling & Student Development Center – Stanley Tam
    - Office – 607-871-2300
CARDIAC ARREST AND AED PROTOCOL

Heart Attack
When the heart is deprived of an adequate amount of oxygen, the heart muscle in the affected area dies. The result is a heart attack. Signs and symptoms of heart attack include:

- Persistent chest pain
- Pain in the left jaw, shoulder, or arm
- Nausea
- Sweating
- Looking/feeling ill
- Shortness of breath

Cardiac Arrest
Cardiac arrest is a condition where the heart stops beating or beats too weakly to circulate blood effectively. A victim in cardiac arrest is unconscious, not breathing and without a pulse. According to the American Red Cross, to allow the victim a chance for survival, cardiopulmonary resuscitation (CPR) must be started promptly followed by defibrillation as soon as possible and early advanced cardiac care. Note: Not every individual who suffers a heart attack goes into cardiac arrest.

Automated External Defibrillator (AED)
An AED is a machine that analyzes the heart’s rhythm and if necessary tells you to deliver a shock to a victim of sudden cardiac arrest. This shock called defibrillation may help the heart to re-establish an effective rhythm.

Precautions of AED Usage

- Do not touch the victim while the AED is analyzing. Touching or moving the victim may affect the analysis.
- Do not touch the victim while defibrillating. You or others could be shocked.
- Do not use alcohol to wipe the victim’s chest dry. Alcohol is flammable.
- Do not defibrillate someone around flammable materials, i.e.: gasoline or free-flowing oxygen.
- Do not use an AED in a moving vehicle. Movement may affect the analysis.
- It is not recommended to use an AED on a victim lying on a conductive surface. Conductive surfaces, such as metal bleachers may transfer the shock, however, the Emergency Cardiovascular Care 2000 Guidelines indicate that this poses no threat to the victim or rescuer.
- Do not use an AED on a victim in contact with water. Move victims away from puddles, a swimming pool, or out of the rain.
- Do not use an AED on an infant or child under age 8 or 55lbs. AED’s do not have the capability to adjust to lower energy settings.
- Do not use an AED on a victim wearing a nitroglycerin patch or other patch on their chest. Remove the patch before attaching the device.
- Do not use a cellular phone or radio within 6 feet of an AED. This may interrupt the analysis.
Guidelines for Usage of an AED

- Only American Red Cross trained and certified individuals should handle the AED (ie. Emergency Medical Technicians, Paramedics, Physicians, American Red Cross Certified Athletic Trainers or Athletic Training Students).
- A retraining session will be conducted at the start of the fall semester before pre-season camps commence.
- A separate annual class will be held for re-certification purposes following American Red Cross Guidelines.
- In order to get certified in AED usage, each student athletic trainer must register, successfully complete (grade of C or higher) and pass all ARC tests in PE 311.
- AEDs are stored in a safe, secure location in the Athletic Training Room, unless on site for an athletic competition or daily practice session. The storage location will be easily accessible at all times in case of emergency.

Protocol for Usage of an AED

1. Determine condition of athlete. Check consciousness, breathing and pulse (ABC’s).
2. If unconscious, specifically identify an individual to summon EMS
   a. on-campus – 9-911
   b. off-campus – 911
3. Treat accordingly.
   a. If no pulse, not breathing, send an individual to retrieve AED from sideline.
   b. If pulse, not breathing, start rescue breathing.
   c. If unconscious, but breathing with pulse, do secondary survey/monitor vitals.
      Note: AED should be present on sideline at ALL home competitions and be easily accessible (ie. in the athletic training room) during daily practices.
4. Turn AED on and follow instructions given by machine.
5. Expose chest and dry with towel. Remove excess hair if possible.
6. Apply pads to bare chest.
7. Plug in connector.
8. STAND CLEAR.
9. Observe all precautions and allow AED to analyze rhythm.
10. If shockable rhythm, make sure everyone is clear of victim. Repeat, “You’re clear, I’m clear, everyone clear, SHOCKING”.
11. Press shock button.
12. Continue until EMS arrives or AED reports no shockable rhythm and treat accordingly.
EMERGENCY AIRWAY/OXYGEN POLICIES AND PROCEDURES

Introduction
In any patient care situation, the first responder must immediately establish and maintain a patent airway. Various procedures and devices are available to assist in this all-important step. Once the airway is established, the first responder must determine whether the patient is breathing. If breathing is adequate, one must provide continued maintenance of the airway and administer supplemental oxygen. If breathing is inadequate, or absent, artificial respiration should be initiated.

Basic Airway Management and Oxygen Administration
In the absence of trauma, the preferred technique for opening the airway is the head-tilt/chin-lift maneuver. With suspected trauma and/or an unconscious patient, the modified jaw thrust technique should be utilized to open the airway.

In the unconscious patient without an intact gag reflex, an oropharyngeal (OP) airway may be inserted into the mouth to lift the base of the tongue forward. A properly sized OP airway will extend from the patient’s mouth to the angle of the jaw or the earlobe.

The nasopharyngeal airway may be inserted into the patient’s nostril to relieve soft-tissue upper airway obstruction in cases where use of an OP airway is not advised (presence of gag reflex, injury to oral cavity, patient’s teeth clenched). A properly sized nasopharyngeal airway is slightly smaller than the diameter of the patient’s nostril and is equal to or slightly longer than the distance from the patient’s nose to earlobe. The nasopharyngeal airway should be lubricated with a water-soluble gel and inserted into the right nostril.

In the field, an airway may be compromised by a number of elements. Suctioning will remove vomitus, blood, and other fluids and secretions from the airway. The Alfred University sports medicine trauma kits are not outfitted with oxygen powered suction or manual (V-Vac) suction.

The Alfred University airway kit is outfitted with supplemental oxygen, bag valve mask (BVM), oropharyngeal airway, nasopharyngeal airway, and non-rebreather masks. Patients should be supplied oxygen at 15 liters per minute through a non-rebreather mask. Patients in respiratory distress or arrest should be given positive-pressure ventilation with a BVM with 100 percent oxygen at 15 liters per minute. When available, continuous cardiac monitoring and O2 sat with pulse oximetry should be utilized with all airway emergencies.

Advanced Airway Management
In an advanced airway situation, the first responder will establish and maintain a patent airway and then assist in the transfer of the patient to a more medically qualified individual or team when arrived. The first responder will assist if needed in any advanced airway procedures performed.

Procedures for Training and Testing in Use of Emergency Airway Management and Oxygen Therapy
Personnel must complete a training session each year, to include instruction in the proper use, maintenance, and periodic inspection of airway and oxygen equipment.

Approved by ___________________________________________     __________________
Team Physician                          Date
EPI-PEN POLICIES AND PROCEDURES

Epinephrine Auto Injector Introduction
In the event of severe allergic reactions, epinephrine will be the treatment drug of choice. Epinephrine is also indicated in the treatment of severe asthma attacks. Epinephrine imitates the actions of the sympathetic nervous system. It strengthens the myocardial contractions, increases systolic blood pressure, increases cardiac rate and output, constricts bronchial arteries and inhibits histamine release. The drug also acts to alleviate wheezing and dyspnea, and reduce swelling and hives. Epinephrine acts quickly (within a few seconds) but is only effective for 15-20 minutes.

The Alfred University Athletic Training Department utilizes the Epi-Pen Auto-Injector as its delivery system. The Epi-Pen delivers epinephrine via a spring-activated needle. When activated, the Epi-Pen will deliver a 0.3 mg of 1:1000 solution of epinephrine to adults when activated. When delivering epinephrine to infants or children under the age of eight (8) or less then 66 lbs, an Epi-Pen Jr. should be used. The Epi-Pen Jr. delivers a .15 mg of 1:1000 solution of epinephrine when activated. With severe persistent reactions, a second dose may be required.

Emergency Care for Anaphylaxis and/or Severe Asthma with Epi-Pen
The athletic training staff should:
- Call for EMS
  - on campus 9-9-1-1
  - off campus 9-1-1
- Maintain an open airway/stabilize head and neck
- If secretions/vomit are present turn patient on side to clear airway
- Administer oxygen therapy at 10 liters/minute with non-rebreather device
- Be prepared to assist ventilation with bag-valve mask or rescue breathing with pocket mask
- Administer epinephrine by a prescribed auto-injector
- Initiate early emergency transport/ Always must transport after injection
- Spine board patient if needed, adhering to spine boarding policy

Indications/ Contraindications/Precautions for Epinephrine Administration
Epinephrine is indicated in the emergency treatment of allergic reactions (anaphylaxis) to various allergens as well as exercised induced anaphylaxis. Patients with severe asthma will present signs of shortness of breath (greater then 30 respirations/min), change in mental status (anxious, confused, drowsy), inability to speak, sweaty, and unable to lie down. Athletes at Alfred University are screened for existing severe allergies. Department policy requires those athletes found to have severe allergies to provide an epi-pen for all practices and games. The Alfred University Athletic Training Department does maintain its own supply as well in the event of an emergency. There are no absolute contraindications to the use of epinephrine in a life-threatening situation. Special precautions should be considered when administering to patients with heart disease. The effects of epinephrine may be potentiated in patients who use antidepressants or monoamine oxidase inhibitors. Individuals with hyperthyroid disease, cardiovascular disease, hypertension, and diabetes may be at greater risk for developing adverse reactions after epinephrine administration. Pregnant women, the elderly, and children under 66 lb (Epi-Pen) and 33 lb (Epi-Pen Jr.) are also at a higher risk of developing complications following epinephrine administration.

STORAGE
Store in tube provided at room temperature (15°-30°C 59°-86°F). Do not refrigerate.

Administration of Epinephrine via Epi-Pen Auto Injector
- Activate EMS
- Check the Epi-Pen to ensure the medication has not expired, has not become discolored (yellowish tinge), and does not contain particles or sediments
- Prep the skin with alcohol
- Remove the gray safety cap from the auto-injector
- Place the tip of the auto-injector against the central muscle belly of the patient’s thigh, midway between the waist and knee
- Thrust the injector firmly against the thigh until the spring-loaded needle is deployed and the medication is injected (at least 20 seconds)
- Dispose of the auto-injector in a biohazard container designed for sharp objects. Be careful not to prick yourself since the needle will now be protruding from the end of the injector.
- Record that epinephrine was administered, the dose, and the time of administration
- Monitor vitals until EMS arrives

**SIDE EFFECTS**

Side effects of epinephrine may include palpitations, tachycardia, sweating, nausea and vomiting, respiratory difficulty, pallor, dizziness, weakness, tremor, headache, apprehension, nervousness, and anxiety.

**POST EPINEPHRINE ADMINISTRATION**

After the administration of epinephrine via Epi-Pen, it is important to monitor vital signs. Reassess the patient’s airway, breathing, and circulation. Decreasing mental status, decreasing blood pressure and increasing difficulty in breathing indicate the allergic reaction or severe asthma is worsening. If the condition is worsening while awaiting EMS, consider the following interventions: injection of a second dose of epinephrine, provide emergency care for shock, be prepared to administer supplemental oxygen or rescue breathing with a pocket mask if breathing becomes inadequate, and be prepared to initiate CPR and apply AED if absence of a pulse is noted.

Be aware that the patient may complain of side effects from the epinephrine. Continue oxygen with a non-rebreather device and treat for shock if necessary. Any patients requiring epinephrine administration should be transported to the closest available medical facility for follow-up evaluation with a physician as soon as possible. Remember that epinephrine is short acting (10-20 minutes) and signs and symptoms may return as the drug wears off.

**Procedures for Training and Testing in Use of Epi-Pen Auto-Injector**

Athletic Training staff and students should complete an Epi-Pen training session each year that clearly reviews the signs and symptoms and emergency care for allergic reactions, anaphylaxis, anaphylactic shock, and severe asthma. The yearly training session should also discuss proper storage, usage, and disposal of an Epi-Pen Auto-Injector. Personnel will be trained using an Epi-Pen Trainer.

__________________________________________ Team Physician

__________________________________________ Head Athletic Trainer

Appendix 1: Epi-Pen Auto-Injector Product Insert
Appendix 2: Nursing Drug Guide Listing for Epinephrine

**References:**

- University of Georgia Sports Medicine Epi-Pen Policies and Procedures, National Athletic Trainers’ Association Web Page.
Spinal Injury Protocol/Procedure

General Guidelines

- Any athlete suspected of having a cervical injury should not be moved. In-line spine stabilization should be maintained and EMS should be activated.
- The athlete’s airway, breathing, circulation, level of consciousness, and neurological status should be assessed. If the airway is impaired, maintain in-line spine stabilization while using a modified jaw thrust maneuver. If the athlete’s breathing is inadequate, assist ventilations with supplemental oxygen.
- Maintain the athlete in the position found unless airway, breathing, or circulation are compromised. If log rolling is necessary to place the athlete in a supine position, extreme caution should be taken to maintain in-line spine stabilization.
- If back boarding is not an option (environmental considerations or lack of sufficiently qualified personnel), at minimum, a rigid collar should be applied to maintain safe in-line spine stabilization.
- Perform a secondary survey while awaiting EMS arrival.

In-Line Spine Stabilization

1. A correctly sized rigid cervical collar should be placed on the athlete.
2. The head and trunk should be moved as a unit by securing the athlete to a spine board. The 6+1 maneuver should be used to place the athlete on the spine board.
3. The rescuer controlling in-line spine stabilization gives commands for the log roll 6+1 maneuver and spine board stabilization.
4. Once positioned onto the spine board, the athlete’s torso and legs should be first secured, using spider straps or speed clips (if speed clips are used, 5 straps should be applied). Two straps should cross the chest from shoulder to opposite axilla, one across the chest under the axilla, one across the pelvis, and one across the distal thighs. The athlete’s wrists may be secured to the spine board using velcro straps or athletic tape.
5. The head should be secured last. 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 restraints (Lateral®) and then secured to the board with velcro straps/tape over the forehead and at the chin.
6. The athlete’s neurological status should be reassessed.
7. The secondary survey should be completed with baseline vital signs (reassessed every 5 minutes), head to toe survey, and a history taken if conscious.
8. Athlete should be transported to the nearest emergency medical facility with proper notification of appropriate personnel. Be sure to follow the Alfred University Catastrophic Injury/Emergency Phone Tree.
Specific Guidelines For Care of Spine-Injured Football Athlete

1. The facemask should be removed prior to transportation, regardless of current respiratory status. Tools for facemask removal (Trainers’ Angel, Cordless Screwdriver, Anvil Pruners, or Cordless Dremmel) should be easily accessible.

2. The football helmet and chin strap should only be removed if:
   3. The helmet and chin strap do not hold the head securely
   4. The design of the helmet and chin strap after removal of the facemask prevents the airway from being controlled and ventilation provided
   5. The facemask cannot be removed after a reasonable period of time
   6. The helmet prevents immobilization for transportation in an appropriate manner
   7. If you are removing the shoulder pads
   8. If the helmet must be removed, spinal stabilization/alignment must be maintained during removal. In most circumstances, it may be helpful to remove cheek padding and/or deflate all air padding prior to helmet removal.
   9. If the helmet is removed then the shoulder pads must be removed on site. However, the front of the shoulder pads can be opened to allow access for CPR and defibrillation and a pocket mask inserted under the facemask.
   10. If either the helmet or shoulder pads are removed, the other must be removed also in order to maintain proper in-line stabilization.

Training in Spine Immobilization

Alfred University Athletic Training staff and students will complete a training session annually on in-line spine stabilization. The training session will consist of reviewing the log rolling maneuver, cervical collar application, proper strapping techniques, and spine board lifting techniques. Additional time will be spent practicing with facemask removal tools and becoming proficient in the removal of shoulder pads.

Approved by: __________________________________________
Team Physician

Approved by: __________________________________________
Head Athletic Trainer
Orthopedic Emergency Injury Protocol

INITIAL EVALUATION
During the initial evaluation of an emergency orthopedic injury, the primary goals of the evaluation are to:

1. Determine if an orthopedic emergency is present
2. Immediately begin appropriate emergency treatment
3. Select the appropriate mode of transportation to the nearest medical facility

When evaluating an orthopedic injury, the first step is to assess both the neurological and circulatory systems of the injured athlete; proper methods for assessing circulation include capillary refill, skin color, and skin temperature. Neurological tests must evaluate dermatomes, myotomes, and any associated reflex. Observation of the injury site for deformity and palpation for irregularities and/or point tenderness should be performed. Torque, compression, and percussion forces may be utilized to test for suspected long bone fractures. Tests that evaluate the joint for gross instability should only be performed if no suspected fractures or dislocations are present. Splints should be applied if gross joint instability or a fracture is suspected. If splints are applied to an extremity, circulation (skin temperature, color, and capillary refill) should be evaluated both before and after the application of a splint.

Remember: Treatment of life threatening injuries/illnesses supersede orthopedic injuries

Orthopedic Emergencies

Any open fractures or dislocations are considered an orthopedic emergency. Immediate treatment for an open fracture or dislocation involves applying a sterile dressing with direct pressure to reduce blood flow and the chance of infection. Direct pressure should be applied with the heel of a gloved hand. If direct pressure does not slow the flow of blood, an arterial pressure point should be used to control bleeding. Using a blood pressure cuff to act as a tourniquet can slow blood flow. Tourniquets should only be applied as a last ditch effort after all other attempts have failed to control the bleeding. Once the bleeding is controlled, treatment is identical to that of a closed fracture with splinting and immediate transport to the closest emergency facility by ambulance.

Note: Be aware of potential internal hemorrhage. Unknown or unseen hemorrhage into the pelvis or femur from a fracture can account for significant blood loss and imminent hemorrhagic shock.

Dislocations of large joints such as the ankle, knee, hip, shoulder, and elbow are viewed as an orthopedic emergency. Dislocations to the knee, hip, and elbow should receive extra attention as these joint dislocations commonly present neurovascular complications. Any delay in the treatment of fractures and dislocations with neurovascular complications may lead to the loss of the extremity or even death. A qualified physician should perform immediate reduction. If a physician or an emergency facility is not readily available for immediate reduction, then a certified athletic trainer who has additional training in large joint dislocation reduction or has verbal orders from the team physician or physician assistant in regards to joint reduction may attempt to reduce the joint.

If the joint is unable to be reduced, the athletic trainer should immobilize the joint in the position found, continue to monitor circulation and sensation, and transport the athlete to the closest emergency facility by ambulance. All orthopedic and vascular emergencies are to be transported to St. James Mercy Hospital.
Splinting Guidelines

The following are guidelines to follow when applying splints.

- Splint only if it will result in decreased pain or for easier transport
- Deformity, gross instability, or crepitus are signs and symptoms for immediate referral to an orthopedic surgeon
- Make sure all open wounds are covered with a sterile compressive dressing
- Be sure to assess the patient’s neuovascular status before and after the application of a splint.
- Pad the splint to prevent pressure over the injury site
- The joint should be immobilized above and below the fracture or dislocation to reduce the amount of movement at the injury site. Do not secure directly over the injury site.
- If there is ever a question whether or not a limb should be splinted, be safe and splint the injured extremity

Splinting Considerations

Splints are used to decrease pain, increase ease of transportation, to prevent a closed fracture from becoming open, to minimize damage to nerves, muscles and blood vessels, and to prevent movement at fracture sites or in the presence of gross instability. The basic rule of splinting is to splint in the position of function or position found. With experience or in the presence of a physician, limb realignment before the application of a splint is acceptable. There are three basic types of splint: 1) rigid, 2) vacuum, and 3) traction. In an orthopedic emergency situation where none of the above are available, an anatomical splint is acceptable to prevent further harm.

Procedures for Training in Orthopedic Evaluation and Splinting/Immobilization:

Certified Athletic Training staff and students complete a training session every year that consists of a review of signs and symptoms of orthopedic injury, evaluation techniques, and splinting/immobilization applications.

Approved by: ________________________________
Team Physician

Approved by: ________________________________
Head Athletic Trainer
Alfred University Division of Athletic Training
Heat Illness Policies and Procedures

08/07/2013

Prevention

While exertional heat illness (EHI) is not always a life-threatening condition, exertional heat stroke (EHS) can lead to fatality if not recognized and treated properly. As the word heat implies, these conditions most commonly occur during the hot summer months; however, EHS can happen at any time and in the absence of high environmental temperatures. Through proper education and awareness, EHS can be recognized, and treated correctly. The occurrence of heat injuries indicates poor supervision of the sports program. Educate your athletes to heed their body’s early warnings of heat stress and to notify you immediately.

Time of Day/Environmental Conditions
Heat stroke incidences tend to occur in the summer months during the afternoon. Most adverse reactions to environmental heat and humidity occur during the first few days of training; therefore it is necessary to become thoroughly acclimatized to the heat in order to successfully compete in hot and/or humid environments. Wet Bulb Globe Temperature (WBGT) readings are used to determine the level of risk. American College of Sports Medicine (ACSM), National Collegiate Athletic Association (NCAA) and National Athletic Trainers Association (NATA) guidelines will be followed, and modifications/cancellations to practice sessions will be implemented if appropriate.

Acclimatization Status
The time period for a thorough and complete heat acclimatization period usually lasts approximately two weeks. The NCAA has policies regarding preseason conditioning and practices and they will be followed. Preseason practices begin two weeks before the first competition day, and conditioning begins 5 days prior to the first practice.

Preconditioning
In order to attempt to prevent heat illnesses from occurring, provide your athletes with a year-round strength and conditioning program. The athlete needs to work out in the type of environment in which he/she will practice and compete in. Individuals who are unaccustomed to working in the heat are at high risk.
Hydration / Food
Water and electrolyte drinks will be provided before, during and after each practice session and proper hydration must be encouraged by all players. *Never deny an athlete the opportunity to take a break.* Encourage athletes to drink before, during, and after practice and to eat good, nutritious foods (i.e. fruits, vegetables, low-fat foods). To prevent dehydration from occurring, athletes should consume 12-20 oz. of cold fluid 10-20 minutes prior to exercise and 8 oz. of cold fluid every 10-15 minutes during exercise. By the time an athlete feels thirsty; they have lost 1% of their body weight. To replace this loss, the athlete should drink one (1) pint of cold fluid for every pound of body weight that is lost during exercise. Do not allow your athletes to eat big, greasy meals immediately prior to activity. Food digestion increases metabolic heat production and also increases water loss.

Hydration status will be determined based on a urine color chart. This chart will be posted in both the athletic training room as well as locker rooms. Urine volume and color can be used to assess general hydration. If output is plentiful and the color is “pale yellow or straw colored” the student-athlete is not dehydrated.

Body mass loss will be measured during initial workouts from pre-to-post practices. The athlete’s percentage of body mass loss must be limited to less than 2% in any session; weigh-ins are useful before and after each session and should be conducted under conditions of high heat and humidity. (Weigh-ins before and after practice sessions only account for water loss during the session and not the state in which the athlete arrived to the session. Athletes often arrive to practice 2% or more dehydrated.) This will help to raise awareness regarding the amount of fluid athletes need to drink to rehydrate. Athletes are required to weigh-in before and after each practice session and an athlete who does not gain back the weight that he/she lost to within 2% in any session will not be allowed to practice.

Intensity Level / Rest Periods
The level of intensity is an important predisposing factor in exertional heat stroke. Higher intensities may promote exertional heat stroke especially during harsh environmental conditions. The risk can be further increased if proper rest does not accompany the high work load. Watch athletes carefully for signs of trouble, especially determined players who may not report discomfort.

Equipment
The most appropriate clothing to wear to prevent heat illnesses should be lightweight, loose fitting and light colored. Clean dry clothes should be worn daily. Long stockings, long sleeves, double jerseys, and other excess clothing should be avoided. Avoiding excessive padding and taping will also contribute in the prevention process. **DO NOT**
allow the use of rubberized clothing or sweat suits. These can be detrimental to an athlete’s health and heat safety.

Football equipment has been shown to increase heat production and retention due to the increased load. This can further reduce the body’s ability to dissipate body heat resulting in an elevated core body temperature. These occurrences are limited by proper equipment restrictions as part of the preseason conditioning/acclimatization guidelines.

Sleep
The proper amount of sleep will be encouraged for all athletes. This can be further monitored according to the athlete’s preseason physical exam. Those athletes who report insufficient sleep practices will be further encouraged as to the importance of proper sleeping habits.

Fitness Level
Individuals with low fitness levels may be at an increased risk for experiencing exertional heat stroke. This will be determined based on their preseason physical exam. Those individuals have characteristics of a low fitness level (i.e. high body fat %, high body mass index (BMI), etc.) will be noted and monitored accordingly. Interior Linemen for example in football tend to have higher BMIs thus are at a higher risk.

Preseason Physical Exam
A standard preseason physical exam will be required of all athletes prior to the beginning of participation. This exam will address past medical history and current health status to determine if the athlete is cleared to participate. All records will be reviewed by the head athletic trainer and the team physician. A history of previous heat illnesses, sweating and peripheral vascular defects, type and duration of training activities done in the past 1-2 months and extent of training in the heat will give you an idea of the athlete’s susceptibility to further heat illnesses.

Illness
Athletes who are ill (i.e. infection, diarrhea, vomiting) are at high risk due to hydration issue. In addition any athletes with a fever will raise the body temperature and will be withheld from practice. There are certain medications (i.e. steroids, alcohol) that limit a body’s ability to raise and lower body temperature and should be discouraged.

Many over-the-counter substances contain stimulants that may increase the risk of heat illnesses. These include nutritional supplements (containing ma huang, caffeine, or ephedrine), drugs (antihistamines, decongestants, asthma medications or Ritalin), and other foods. The use of these is cautioned in the heat and the use of laxatives, emetics, and diuretics are prohibited by Alfred University.
Recognition of Signs and Symptoms

Definitions

Heat Cramps
The mechanism of heat cramps is unknown but they can be caused by poor hydration or lack of adequate salt in the diet. Cramping is not a cause of sudden death, but can be confused with a more serious condition, exertional sickling (cramps with no muscle contraction). Heat cramps are painful cramping often in the legs, arms, or abdomen with positive muscle contraction when felt. Cramps can easily be treated with decreased activity and rehydration of fluid and electrolytes. Place the athlete in a cool environment. Give the athlete fluids and remove constrictive clothing. Stretch the affected muscle; contract the antagonist muscle.

Heat Exhaustion
Heat exhaustion is characterized by a body temperature ranging from 98°F (normal) to 104°F. Other common symptoms include fatigue; weakness; low blood pressure, tachycardia, apprehensiveness; cold, damp, and ashen skin; nausea; vomiting; headache; dizziness; faintness; irritability; loss of appetite; profuse sweating; hyperventilation; muscle spasms/cramps; weak pulse; thirst, decreased urine output; dehydration and unconsciousness. Treatment includes: Moving the athlete to a cool/shaded area, remove excess clothing, elevate legs to promote venous return, cool the individual with fans, rotating ice towels, or ice bags and provide oral fluids for rehydration

Exertional Heat Stroke (EHS)
Heat Stroke is an extremely SERIOUS, LIFE-THREATENING condition requiring IMMEDIATE medical attention.

Core Temperature Assessment
An elevated core temperature is the key for making a diagnosis of exertional heat stroke. Heat stroke is characterized by sudden onset/rise of body temperature (104 degrees F or higher). If an elevated core temperature is suspected, athlete will be cooled immediately and temperature will be taken. The measurement will be done with a rectal thermometer (unless an ingestible thermometer had been used). If a rectal thermometer is not accessible another form of temperature device should not be substituted due to inaccurate measurements.

CNS Dysfunction
CNS dysfunction is the second key of the diagnosis of exertional heat stroke. These symptoms include but are not limited to: disorientation, staggering, confusion, poor judgment, dizziness, unusual and possibly bizarre behavior, lethargy, irritability, headache, collapse, fatigue, delirium, seizures, and coma.
Signs and Symptoms
Initial diagnosis will be made according to the CNS symptoms listed above in addition to the level of hyperthermia (core body temperature > 104°F). In addition, other vital sign readings often include weakness hot and wet skin (dry skin is only an extremely late sign of EHS and more common in classical heat stroke cases), tachycardia (100 to 120 beats per minute), hypotension, hyperventilation, vomiting, diarrhea. Further assessment/tests will be made once transported to a medical facility, if necessary.

Differential Diagnosis
Common differential diagnoses of exertional heat stroke include, but are not limited to heat cramps, heat exhaustion, heat syncope, and hyponatremia. The following conditions may add to the risk of exertional heat stroke: malignant hyperthermia, arteriosclerotic vascular disease, scleroderma, cystic fibrosis, and sickle cell trait.

EHS Treatment

Rapid Cooling
The goal of rapid cooling should be to reduce the core temperature to 102.5°F within 30 minutes of collapse. The athlete should immediately be moved to a cool / shaded environment and placed in the cold water immersion tub (water temperature approx. 45 - 60°F). Restrictive clothing will be loosened or removed. Vital signs will be done every 5 minutes. STIRRING WATER EVERY 3 MINUTES. All medical personnel and team coaches should have access to the tub for prompt treatment of patients with EHS. The tub should be set up on site for all high-risk activities, especially those performed during summer conditioning sessions and August and early September practices.

Transportation
Transportation will occur via emergency medical service (EMS) to a local hospital ONLY after cooling has been completed. The doctrine of “cool first and transport second” will be followed if appropriate medical professionals (medical doctor, ATC, or EMS) are on site when treating EHS.

Core Temperature Monitoring
Core temperature monitoring via rectal thermometer will begin immediately and will continue during active cooling and post cooling (including during transportation).

Ambulance Policy
EMS will be notified by either the head athletic trainer or the coaching staff and will instruct the ambulance as to the location of the athlete and the nature of the injury. A member of the coaching staff will wait for the ambulance to arrive and direct them to the appropriate route.
Approximate Treatment Time

The treatment time will vary depending on the extent of hyperthermia. Based on a cooling rate of approximately 0.20°C/min., and assuming a starting core temperature of 104°F-109°F, treatment time should range between 8 minutes and 35 minutes, respectively.

Monitoring

The Wet Bulb Globe Temperature (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 temperature and humidity and is calculated for shady areas. Whereas WBGT is optimal for assessing the environmental stress, the heat index can provide an adequate reading if WBGT is not available.

Activities should be modified when environmental conditions are extreme. The WBGT should be used to determine these modifications, but specific WBGT thresholds for activity alterations may vary based on geographic location. The NCAA Guidelines dictate appropriate rest breaks, including duration and total number, for practice sessions and should depend on session length and intensity of activity.

Wet Bulb Globe Temperature

WBGT devices measure air temperature, humidity with a wet “bulb” that needs to stay moistened with water to simulate evaporation of sweat, and radiant or solar heat with a six-inch-diameter black globe. They connect to a processor to calculate an integrated WBGT index reading.

A wet-bulb temperature higher than 75°F or humidity above 90% may represent dangerous conditions.
A wet-bulb globe temperature (WBGT) higher than 82°F suggests that careful control of all activity be undertaken or cancelled altogether.

<table>
<thead>
<tr>
<th>WBGT</th>
<th>Flag Color</th>
<th>Level of Risk</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;65°F (&lt;18°C)</td>
<td>Green</td>
<td>Low</td>
<td>Risk low but still exists on the basis of risk factors</td>
</tr>
<tr>
<td>65°F-73°F (18°-23°C)</td>
<td>Yellow</td>
<td>Moderate</td>
<td>Risk level increases as event progresses through the day</td>
</tr>
<tr>
<td>73°F-82°F (23°-28°C)</td>
<td>Red</td>
<td>High</td>
<td>Everyone should be aware of injury potential; individuals at risk should not compete</td>
</tr>
<tr>
<td>&gt;82°F (&gt;29°C)</td>
<td>Black</td>
<td>Extreme or hazardous</td>
<td>Consider rescheduling or delaying the event until safer conditions prevail; if the event must take place, be on high alert. Take steps to reduce risk factors (e.g., more and longer rest breaks, reduced practice time, reduced exercise intensity, access to shade, minimal clothing and equipment, cold tubs at practice site, etc.).</td>
</tr>
</tbody>
</table>
Heat Index
In absence of a WBGT measuring device the heat index can be estimated by using a sling psychrometer. A sling psychrometer is an instrument that measures relative humidity (a hygrometer). The sling has two thermometers, a dry bulb and a wet bulb thermometer, mounted together on a chain.

Slings have been around for years, and are becoming less and less used for many reasons. With the advent of digital hygrometers, it's just easier to pull out a device and read the screen. Additionally, besides being cumbersome and time consuming, slings contain mercury, a hazardous material, and must be handled with care. A sling will typically read 5-10% high due to user error. Some of the mistakes that can be made while using a sling are:

1. If the sock on the wet bulb thermometer is not clean, the humidity measured from a sling will err on the high side.
2. If the water used for the wet bulb thermometer is not distilled water, the humidity measured from a sling will err on the high side.
3. If the sling is not swung around long enough, the humidity measured from a sling will err on the high side.
4. If the thermometer measurements are not read quickly enough after swinging the sling, the humidity measured from a sling will err on the high side.

The heat index reading is a method of determining environmental conditions, which would predispose athletes to heat illnesses. The difference between the thermometer readings on a sling psychrometer (wet bulb/dry bulb) constitutes a measure of the dryness or wetness of the surrounding air. The relative humidity is calculated from the difference between the dry and wet bulb readings.

Technique for measuring the Heat Index utilizing the sling psychrometer:
1. Wet the wick on the wet bulb portion of the sling psychrometer
2. Stand in the middle of the practice field, not just outside of the athletic training nor in a shaded area or next to buildings.
3. Sling the psychrometer overhead for five minutes
4. Always measure the Heat Index within 10-15 minutes of the beginning of practice
5. After five minutes, take both a wet bulb and dry bulb reading
6. Note where the two readings converge on the scale to determine the heat index
7. Utilize the chart below to determine the course of action for the practice
8. Measure and record the Heat Index every 45-60 minutes during a practice session
# Wet Bulb Globe Temperature (WBGT) from Temperature and Relative Humidity

<table>
<thead>
<tr>
<th>Temperature (°C)</th>
<th>Relative Humidity (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>0</td>
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<tr>
<td>21</td>
<td>15</td>
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<td>49</td>
<td>43</td>
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<tr>
<td>50</td>
<td>44</td>
</tr>
</tbody>
</table>

Note: This table is compiled from an approximate formula which only depends on temperature and humidity. The formula is valid for full sunshine and a light wind.
<table>
<thead>
<tr>
<th>Temperature (Fahrenheit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative Humidity at Site</td>
</tr>
</tbody>
</table>

| 75 | 80 | 85 | 90 | 95 | 100 |
|-------------------------|
| 1.00 | 0.97 | 0.94 | 0.91 | 0.88 | 0.85 |
| 1.00 | 0.97 | 0.94 | 0.91 | 0.88 | 0.85 |
| 1.00 | 0.97 | 0.94 | 0.91 | 0.88 | 0.85 |
| 1.00 | 0.97 | 0.94 | 0.91 | 0.88 | 0.85 |
| 1.00 | 0.97 | 0.94 | 0.91 | 0.88 | 0.85 |
| 1.00 | 0.97 | 0.94 | 0.91 | 0.88 | 0.85 |

**AU**

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Alfred, NY 14802
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Cold Weather Policy

PHYSIOLOGICAL EFFECT OF COLD STRESS
Strength, power, endurance, and aerobic capacity are reduced by a drop in muscle temperature or core body temperature. Musculoskeletal injuries may increase when exercising vigorously in the cold, especially in the absence of adequate warm-up.

RECOGNITION OF COLD STRESS
Early recognition of cold stress is important. Shivering is a means for the body to generate heat and serves as an early warning sign. Excessive shivering contributes to fatigue and makes performance of motor skills more difficult. Other signs include numbness and pain in the fingers and toes or a burning sensation of the ears, nose, or exposed flesh. As cold exposure continues the core temperature drops. When the cold reaches the brain, a victim may exhibit sluggishness, poor judgment, and may appear disoriented. Speech becomes slow and slurred, and movements become clumsy. The victim wants to lie down and rest. This is a medical emergency!

PREVENTION OF COLD STRESS
I. Proper Clothing
Prevention of cold stress is a matter of dressing appropriately and controlling the climate which contacts the skin. Student-athletes should dress in layers and try to stay dry. Layers can be added or removed depending on temperature, activity, and wind chill. Begin with a wicking fabric next to the skin. Add lightweight pile or wool layers for warmth and use a wind block garment to avoid wind chill. Because heat loss from the head and neck may be as much as 50 percent total heat loss, the head should be covered during cold stress conditions. Mittens are warmer than gloves for hand covering. Moisture, such as perspiration or precipitation increases heat loss. Keep dry by wearing a wicking fabric next to the body, i.e. polypropylene or wool. Cotton is a poor choice due to its ability to hold moisture.

II. Proper Hydration
Keep energy levels raised by eating meals and properly hydrating with water and electrolyte drinks. Improper energy levels increase susceptibility to hypothermia. Dehydration affects the body’s ability to regulate temperature and increases the risk of frostbite. Avoid alcohol, nicotine and caffeine which can increase susceptibility by causing dehydration.

III. Fatigue
Fatigue and exhaustion depletes energy reserves. Exertional fatigue increases susceptibility to hypothermia.

IV. Proper warm-up
Warm-up thoroughly and keep warm during practices to prevent a drop in muscle/core temperature. Time the warm-up to lead almost immediately into the competition.

Guidelines for Prevention of Cold Stress for Practice or Competition
The policy of the Alfred University Athletic Training Department is as follows:

I. Normal practice. Take precautions and dress appropriately. (Temperatures and wind speed are not on the chart.)
II. Caution for practice. Be aware of drastic drops in temperature and changes in wind speed. (White region of the chart.)
III. Limit practice length due to wind speed and temperature and potential for hypothermia. (Gray region of the chart.)
IV. No outdoor practice due to potential of human flesh freezing. (Black region of the chart.)

Lightning Policy

INTRODUCTION

Three-quarters of all lightning casualties occur between May and September, and nearly four-fifths occur between 10:00am and 7:00pm, which coincides with the hours of most athletic events. Additionally, lightning casualties from sports and recreational activities have risen alarmingly in recent decades. About 100 people die and hundreds more are injured each year in lightning-related accidents.

A cloud-to-ground lightning flash is the product of the buildup and discharge of static electric energy between the charged regions of the cloud and the earth. The negatively charged lower region of the clouds induces an attraction with various objects on the ground producing positively charged upward streamers. The connection of the step leader with an upward streamer determines the connection point on the ground. Heat lightning is cloud-to-cloud lightning that is too distant to hear accompanying thunder. Thunder is created when the air around lightning is superheated to temperatures of \( \geq 50,000^\circ F \), 5 times hotter than the sun. The rapidly heated air around the channel explodes creating the clapping or crash of thunder. The audible range of thunder is approximately 10 miles.

It is important to be aware the lightning can occur without thunder but thunder never occurs in the absence of lightning.

“FLASH-TO-BANG”

The “flash-to-bang” method is a simple method which assists in determining your distance from the lightning flashes and subsequent storm center. Begin by counting (one-one thousand, two-one thousand, etc.) as soon as a lightning flash is observed. Stop counting as soon as a successive thunder sound is heard. Divide the number of seconds by five (5) and the resulting number is the distance in miles the lightning flash is from the practice/game area. If the number is \( \leq 6 \) (= 6 miles or 30 seconds) then the practice or game area must be evacuated IMMEDIATELY.

Optimal shelter should be sought, preferably a sturdy building with metal plumbing and/or metal wiring. If this is not available, an alternative (but inferior) shelter is a vehicle with rubber tires. If a storm is imminent and you are unable to safely evacuate an area, assume the lightning safe position. Crouch down with your feet together, hug your knees and lower your head. The idea is to minimize surface area contact with the ground to a single point. Two or more points of contact or a large surface area could attract lightning/electricity to circulate through your body. DO NOT ever lie flat on the ground.

NOTE: Baseball and softball dugouts do not meet criteria for safe shelters.

The responsibility for removing athletes from the practice/game area lies with the coach who works under the advisement of the certified athletic trainer, if present, or the head coach of the particular sport alone when an ATC is not present (i.e. non-traditional). If the head coach is not present, then the assistant coach would assume the role of responsibility. The certified athletic trainer and/or athletic training student will observe and track the “flash-to-bang” count and inform the coach when conditions become dangerous and the need to evacuate arises.

Personnel may return to the practice/game area once 30 minutes has elapsed since the last lightning flash was observed or thunder sound was heard. There are no exceptions. If a lightning flash or thunder sound occurs after 30 minutes time has elapsed, the clock resets and the practice/game area must again be evacuated to the safe shelter.
Lightning Safety Guidelines

- Stay away from tall trees, lone objects (flagpoles, telephone poles, etc), metal objects (fences, bleachers, etc.), standing water, and open fields.
- Be especially careful with sport equipment such as lacrosse sticks or baseball/softball bats. DO NOT raise them into the air. Due to their metal properties they could behave as lightning rods.
- Unless there is an emergency, do not use a landline phone or computer and avoid using plumbing (including whirl pools and showers).
- Do not hesitate to help a victim of a lightning strike. They do not carry a residual charge.
- The absence of rain does not eliminate the possibility of lightning. Lightning can strike up to ten (10) miles away from the center/eye of a storm.
- If there is no safe shelter, try to take cover in a thick grove of small trees surrounded by taller trees or in a dry ditch and assume the lightning safe position (see above).
- Avoid the highest point, open fields or open water.
- Individuals who feel their hair stand on end or skin tingle or hear crackling noises should assume the lightning safe position (see above).

MANAGING LIGHTNING STRIKE VICTIMS

- Survey the scene. Ongoing thunderstorms are still an imminent threat. Your safety comes first.
- Activate EMS (911 off-campus, 9-911 on-campus).
- Move the victim to a safer location, preferably indoors.
- Evaluate and treat for
  - Apnea (cessation of breathing) with rescue breathing.
  - Asystole (absence of pulse) with CPR or optimally AED.
- Evaluate and treat for hypothermia and shock.
- Evaluate and treat for fractures. Splint as needed.
- Evaluate and treat for burns.

SAFE SHELTERS

McLane Physical Education Center
Merrill Turf Field
Harrington Softball Field
Tennis Courts
Jericho Fields

Alfred State Orvis Activities Center
Alfred State Outdoor Track
Hornell High School
Hornell Softball Fields

Asthma Medication / Inhaler Policies and Procedures

9/23/13

In both the athletic and non-athletic population, many individuals are affected by asthma. Two types of medication are commonly prescribed to treat individuals suffering from asthma; quick relief medications to be used on an as-needed basis, or prophylactic medication designed to provide long-term control and reduce the risk of future attacks.

1. Commonly used quick relief medications treat the symptoms associated with an asthma attack; they include albuterol-based Proventil and Ventolin, and pributerol-based Maxair. These prescribed drugs relax the smooth muscles that line the airways of the respiratory system.

2. Long-term medications for the treatment of asthma are used daily by the patient and are designed to prevent associated symptoms. Inhaled steroids are commonly used to reduce the likelihood of an asthma attack by decreasing mucus production as well as reducing the amount of swelling present in the airways. Typically prescribed inhaled steroids include Beclovent, Azmacort, Flovent, and Pulmicort. New long-term medications used in the treatment of asthma are leukotriene modifiers. These drugs are designed to reduce the amount of swelling and spasm found in the smooth muscles of the airway. Examples of leukotriene modifiers are Accolate and Singulair.

Medication Administration

The typical route of administration for most asthma medication is inhalation. Many aerosol devices are used to deliver prescribed medications through a metered-dose inhaler (MDI). The medications may be delivered through a MDI with our without a spacer. The spacer is designed to hold the medication in the chamber of the inhaler long enough for the patient to effectively inhale all of the medication within two deep breaths. It is essential that the patient and athletic training staff be proficient in the use of a MDI in order for sufficient administration of the medication.

1. If possible, measure peak flow
2. The cap of the MDI should be removed
3. The inhaler should them be shaken
4. The patient should then be instructed to tilt their head back slightly and breath out.
5. Have the patient open their mouth and hold the inhaler without a spacer approximately 1-2 inches away. If a spacer is provided, the mouth should be placed on the spacer.
6. The patient should then be instructed to press down on inhaler canister and breath in slowly.
7. Have the patient hold their breath for approximately 10 seconds.
8. If prescribed, repeat puffs.
9. Repeat the measurement of peak flow.

**Asthma Screening and Management Procedure**

1. All asthmatics will be identified via pre-participation screening examination and medical history forms completed by all Alfred University athletes.
2. All Alfred University athletes will have a peak flow test performed during the pre-participation screening process. This test will be taken with the patient at rest and documented on the medical evaluation form.
3. Any exacerbations will be documented in the athletic training room software as well as in the athlete’s medical folder located within the Alfred University Athletic Training Room.
4. Any change in asthma medications will also be documented in the athletic training room software as well as in the athlete’s medical folder located within the Alfred University Athletic Training Room.
5. All athletes who have a significant asthma exacerbation, as determined by change in peak flows or certified athletic trainer’s discretion, need to be seen by an Alfred University Team Physician prior to resumption of activity.

**Emergency Treatment and Management of Severe Asthma Episodes**

Signs and symptoms associated with a severe asthma episode include a variety of conditions. Generally, patients will exhibit labored respirations, inability to speak clearly, shortness of breath with greater than 30 respirations per minute, and changes to their mental status. Patients may also complain of lightheadedness and dizziness; this may ultimately lead to blurred or double vision. In the event an asthma episode has progressed to the patient being rendered unconscious or unable to use their MDI, the following steps should be taken.

1. Activate EMS
2. Monitor or maintain, airway, breathing, and circulation.
3. Oxygen should be administered at 15 liters / minute with a non-rebreather device.
4. Assist ventilation with bag valve mask if needed.
5. Administer epinephrine by using a prescribed Epi-Pen auto-injector.
6. Stabilize and continue to monitor patient vital until EMS arrives.
Training in the Use of a MDI and Asthma Protocols

All Alfred University Athletic Training personnel will complete a yearly training and review session covering the Division of Athletic Training’s policies regarding asthma management, as well as instruction on the use of a MDI.

________________________________________ Team Physician

________________________________________ Head Athletic Trainer

References:

Developed: 4/30/03
Revised: 9/23/13
EATING DISORDER POLICY / PROCEDURE

The Alfred University Athletic Training Department promotes the advocacy of a healthy lifestyle for student athletes. Disordered eating is an issue that concerns all university personnel. Recovery from eating disorders can be a difficult process that takes time. In general, the greater the duration and frequency of disordered eating, the longer it will take for recovery to occur. The Alfred University policy is based upon eventual recovery from the disease through assistance from a variety of health professionals.

The following definitions are based on the criteria in the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV):

**Anorexia Nervosa**

1. Refusal to maintain body weight at/or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
2. Intense fear of gaining weight or becoming fat, even though underweight.
3. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
4. Amenorrhea in postmenarcheal females (i.e., the absence of at least three consecutive menstrual cycles).

The following are lists of behavioral and physical signs commonly associated with anorexia. The list is not all-inclusive. The student athlete’s behavior and physical signs should be monitored in order to observe all characteristics.

**Behavioral Signs:**

1) Reports feeling “fat/heavy” despite low body weight
2) Obsessions about weight, diet, appearance
3) Ritualistic eating behaviors
4) Avoiding social eating situations, social withdrawal
5) Obsession with exercise; hyperactivity – may increase workouts secretly
6) Feeling cold
7) Perfectionism followed by self-criticism
8) Seems anxious/depressed about performance and other events
9) Denial of unhealthy eating pattern – anger when confronted with problem
10) Eventual decline in physical and school performance

**Physical Signs:**

1) Amenorrhea (lack of menstrual periods)
2) Dehydration (not related to workout-competition)
3) Fatigue (beyond expected)
4) Weakness, dizziness
5) Overuse injuries, stress fractures
6) Yellow tint to hands
7) Gastrointestinal problems
8) Lanugo (fine hair on arms and face)
9) Hypotension (low blood pressure)
Bulimia Nervosa

1. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   a. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
   b. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
2. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
3. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.
4. Self-evaluation is unduly influenced by body shape and weight.
5. The disturbance does not occur exclusively during episodes of Bulimia Nervosa.

The following are lists of behavioral and physical signs commonly associated with bulimia nervosa. The list is not all-inclusive. The student athlete’s behavior and physical signs should be monitored in order to observe all characteristics.

**Behavioral Signs:**

1) Excessive exercise beyond scheduled practice
2) Extremely self-critical
3) Depression and mood fluctuations
4) Irregular weight loss/gain; rapid fluctuations in weight
5) Erratic performance
6) Low self-esteem
7) Drug or alcohol use
8) Binges or eats large meals, then disappears

**Physical Signs:**

1) Callous on knuckles
2) Dental and gum problems (bad breath)
3) Red puffy eyes
4) Swollen parotid glands (at the base of the jaw)
5) Edema (bloating)
6) Frequent sore throats
7) Low or average weight despite eating large amounts of food
8) Electrolyte abnormalities
9) Diarrhea, alternating with constipation
10) Dry mouth, cracked lips
11) Muscle cramps/weakness

**Treatment and Intervention**

1. If an athletic department staff member witnesses or has reports of a student-athlete displaying signs or symptoms of an eating disorder (see “Behavioral and Physical Signs of an Eating Disorder”), then he or she is to approach the student-athlete. If a teammate witnesses a student-athlete engaging in disordered eating behaviors, the teammate will be encouraged to approach the coach of the team the athlete is a member of, or inform a certified member of the Athletic Training Department. Also athlete will be referred to Health services for further help (this is a mandatory process).

2. Appropriate confrontation revolves around displaying an expression of concern that the student-athlete is exhibiting specific eating behaviors that may interfere with his or her health and athletic performance (see “Approaching a Student-Athlete about Disordered Eating”). The staff member
will request that the student-athlete meet with the team physician, an Alfred University
psychologist, and/or a registered dietitian.

3. If it is determined that the athlete does in fact have an eating disorder, then the medical staff will
develop a treatment plan for the student-athlete. The treatment plan may include:
   - Scheduled visits with the team physician, athletic trainer, a university psychologist, and a
     registered dietitian
   - Weight checks as outlined by team physician or registered dietitian
   - Limitation of physical activities
   - Any other intervention as deemed medically or psychologically necessary

4. If the student-athlete does not seek help independently and the disordered eating behaviors
continue, the staff member will notify the student-athlete that he or she will be referred to the team
physician and other medical supports staff members if necessary.

5. The medical staff will meet with the student-athlete to oversee his or her compliance with the
treatment plan. The student-athlete will be required to sign a contract agreeing to the terms of the
plan, suspension from sport will result.

6. The treatment team will review the student-athlete’s case periodically and provide further
intervention as needed.

Guidelines for coaches:

1. If a coach wants a student-athlete to modify his or her diet, the coach will refer the student-athlete
to the athletic trainer.

2. The athletic trainer works closely with medical staff (physician, dietitian, strength and
conditioning coach) and will help the student-athlete to utilize these resources.

3. Coaches will not weigh student-athletes in group settings. Body weight / composition is private
information.

Guidelines for Confronting Student Athlete with Suspected Eating Disorder

1. A coach or staff member who has the best rapport with the student-athlete should arrange a private
meeting.

2. In a calm and respectful manner, indicate to the student-athlete what specific observations were
made that aroused your concerns. Give the student-athlete time to respond. Use “I” statements.
   (I’m concerned about you because you refuse to eat breakfast or lunch. It worries me to hear you
   vomiting.) Avoid “You” statements and discussions about weight or appearance. (You are too thin
   and you have to eat! You’re out of control.) Avoid giving simple solutions. (If you’d just eat more,
   everything would be fine) Affirm that the student-athlete’s role on the team will not be jeopardized
by an admission that a problem exists.

3. The student-athlete’s reaction may be one of denial or perhaps hostility. Firmly encourage the
student-athlete to meet with a professional for an assessment, acknowledging that outside help is
often necessary for eating problems and is not a sign of weakness.

Sources:

1. Eating Disorders Awareness and Prevention; Laura Hill, Ph.D.
2. Ohio State University Department of Athletics Eating Disorder Policy 2001.
Menstrual Dysfunction and Pregnancy Policies

FEMALE ATHLETE TRIAD
The relationship between amenorrhea, osteoporosis and disordered eating is termed the “female athlete triad”. Any student-athlete that presents with one component of the triad should be screened for the other two components and referred for a pelvic examination and further medical evaluation.

Amenorrhea
The absence of menstruation, or amenorrhea, is often a consideration for female athletes. Amenorrhea may be primary (menstruation does not occur by age 18) or secondary (menstruation has occurred but has ceased since).

Research has suggested that amenorrheic athletes more readily develop bone density deficiencies, musculoskeletal injuries (i.e. stress fractures) and are at early risk for osteoporosis. The female athlete triad may have a direct relationship on the function of the hypothalamus and regulation of hormone levels (specifically estrogen). Excessive exercise, limited caloric intake (specifically carbohydrates) and physiological stress (training volume) decrease the frequency of gonadotrophic-releasing hormone (Gn-RH) pulses secreted by the hypothalamus and limit the availability of estrogen. A decrease in these hormone levels can lead to amenorrhea and increased chances for bone resorption (decreased bone mineral density).

Disordered Eating (See also Alfred University Eating Disorder Policy)
Athletes, typically runners and gymnasts, maintain a low body weight for performance purposes. With continual increased workloads, disordered eating patterns tend to develop. Controlling caloric intake by utilizing diet pills, laxatives, diuretics, vomiting and fasting (or binge and purge) characterize conditions of disordered eating. Limiting caloric intake can create a negative energy balance (where energy expended is greater than energy/calories taken in) resulting in physical fatigue, poor performance, menstrual dysfunction and osteoporosis (long-term).

Osteoporosis/Bone Mineral Density
For many female athletes, bone loss is not a concern because exercise can actually increase bone density. However, in amenorrheic women, the risk for osteopenia (bone density loss throughout life) increases in trabecular bone regardless of regular exercise. Osteopenia is the primary cause of premenopausal osteoporosis. Trabecular bones, more metabolically active bone composing 20% of the skeleton can be more sensitive to hormonal fluctuations. This type of bone is concentrated in the pelvis but also in flat bones (tibia), the ends of long bones (femoral neck, greater trochanter) and the vertebral bodies (lumbar spine).

According to research, if normal menses does not return the trabecular bone loss (BMD loss) can be irreversible, especially in primary amenorrheic women regardless of estrogen replacement and calcium supplementation.

MENSTRUAL CYCLE DYSFUNCTION
Menstrual cycle irregularities have been reported to be as high as 44% in athletic women. The length of the menstrual cycle ranges from 23-35 days in 80% of all college-age women. The failure to increase the dietary energy intake in compensation for the expenditure of energy during exercise can disrupt the hypothalamic-pituitary-ovarian (HPO) axis. The long-term effects of menstrual cycle dysfunction appear to be reversible.
The most common menstrual irregularities include oligomenorrhea, an inconsistent menstrual cycle (longer intervals or irregular); amenorrhea, the cessation of the menstrual cycle with ovulation occurring infrequently or non-existent; and dysmenorrhea, debilitating pain in association with menstruation. Dysmenorrhea is the greatest single cause of absence from school and/or work among menstrual-age women. An estimated 50% of menstruating women experience this disorder.

Medical consequences of menstrual irregularities include skeletal demineralization throughout the entire skeleton, especially in hypoestrogenic women. Women with menstrual disturbances involved in high impact activities such as gymnastics and figure skating display less demineralization than women runners. The loss of bone mass is not completely reversible which may increase the potential for osteoporotic fractures later in life. An increased incidence of stress fractures also has been observed in long bones and feet of women with menstrual irregularities.

**PREDISPOSITIONS FOR COMPONENTS OF THE FEMALE ATHLETE TRIAD**
- Prior menstrual dysfunction
- Participation in appearance-based sports (swimming, gymnastics, cycling, cheerleading)
- Poor nutrition/vegetarian diet
- Low body weight

**Prevention and Management of Menstrual Irregularities**

The ultimate goal of any treatment for any women suffering from menstrual irregularities is to re-establish an appropriate environment for maintaining bone health and stopping demineralization. This can be achieved by two means: establishing a normal menstrual cycle and/or hormone replacement therapy. However, neither change has been shown to lead to recovery of lost bone mass.

All student-athletes with menstrual irregularities, once identified, should receive:

1. A full medical evaluation including endocrine work-up and bone mineral density testing to create a baseline.
2. Nutritional counseling with emphasis on:
   - The importance of total caloric intake being greater than energy expenditure
   - Calcium intake of 1200 to 1500 milligrams daily (whether dietary or supplemental)
3. Routine monitoring of diet, menstrual function, weight-training schedule and exercise habits.

* If little or no success is observed with the above, estrogen-progesterone supplementation coupled with hormone replacement therapy should be considered.

**PREGNANCY AND THE STUDENT-ATHLETE**

There are no studies that specifically address the topic of strenuous physical activity and the pregnant student-athlete. Healthy pregnant women are encouraged to engage in regular, moderate intensity physical activities.

**Benefits for the Mother**
- Improved cardiovascular function
- Limited weight gain and fat retention
- Improved attitude and mental state
- Easier and less complicated labor
- Enhanced postpartum recovery

**Benefits for the Fetus/Infant**
- An increased tolerance for physiological stresses in late pregnancy, labor, and delivery
- Tend to be more alert
RISK OF PARTICIPATION FOR THE PREGNANT STUDENT-ATHLETE

Safety of participation in each sport must be dictated by the movements and physical demands required. Exercise in the supine position after the first trimester results in relative obstruction of venous return and orthostatic hypotension. Activities such as weightlifting or other activities requiring similar strain or valsalva therefore should be avoided.

High intensity exercise is required as a component of nearly all sports and can result in increased risk to the fetus. Participation in competitive contact sports should be avoided after the 14th week (3-½ months) of pregnancy. Athletic activities associated with a high risk of falling should altogether be avoided during pregnancy. Non-contact endurance sports should be considered at a non-competitive level.

Women who are at a high risk for complications during pregnancy should avoid all physical activity until consulting their obstetrician. Such high-risk conditions/complications include: poorly controlled diabetes or hypertension, multiple gestation (risk of pre-term labor), pre-eclampsia, and cervical defects (risks of spontaneous abortions).

WARNING SIGNS FOR TERMINATION OF ATHLETIC PARTICIPATION

- Vaginal bleeding
- Shortness of breath prior to exercise
- Dizziness
- Headache
- Chest pain
- Calf pain or swelling
- Pre-term labor
- Decreased fetal movement
- Amniotic fluid leakage
- Muscle weakness

*If any one or more of these symptoms are experienced by the pregnant student-athlete, the managing obstetricians and team physician should be consulted immediately.

CLEARANCE AND PARTICIPATION OF THE PREGNANT STUDENT-ATHLETE

The team physician should discuss in a counseling session the effects of pregnancy on competitive abilities, strenuous physical training and competition on the student-athlete and fetus, and the warning signs of the need to terminate physical exercise with the pregnant student-athlete prior to continuing participation or receiving clearance.

If the student-athlete decides to compete and is given individual written clearance by the team physician and obstetrician (whose care she is under), it is recommended that documentation outlining the existing medical condition and the substance of the counseling session be included in the student-athlete’s medical record with the student-athlete’s signature of consent. Another documentation is required following delivery, prior to the student-athlete’s return to athletics. This is to ensure a safe return to play.

PRESCRIPTION / OVER THE COUNTER DRUG POLICY

Medications:

The Alfred University Athletic Training Department currently provides over-the-counter (OTC) and prescription medications to athletes as needed. It is important that all Athletic Training Department personnel fully understand and comply with laws and regulations governing the administration and dispensing of drugs.

Administering drugs refers to the direct application of a single dose of drug. Dispensing is defined as preparing, packaging, and labeling a prescription drug or device for subsequent use by a patient. Physicians cannot delegate to athletic trainers the authority for dispensing prescription medications under current dispensing laws.

- All over-the-counter and prescription medications will be stored in a locked compartment within the athletic training room.
- Only staff athletic trainers and team physicians will be permitted to access the medication supply and its contents will be tightly controlled and tracked.
- All prescription and OTC medications which are given to student-athletes and/or athletic department staff members must first be prescribed by a physician and must be logged on the appropriate forms located within the secured storage space.
- All prescription and OTC medications will be examined regularly to ensure quality. Outdated, deteriorated, and recalled medications will be handled in the appropriate manner.
- Athletic team kits, which house OTC medications, will also be inspected on a regular basis to ensure drug quality.
- Any individuals that receive medication should be properly informed about the effects of the drug they are taking. The Athletic Training Staff should discuss the possible side effects, rule out any drug allergies, as well as any known drug interactions.
- Inform all individuals receiving medications that they must report any side effects or allergic reactions associated with taking the medication.
- The Athletic Training Staff should follow-up with the athlete to ensure proper drug usage.
Medical Records and Confidentiality Policies

Privacy and Confidentiality:

All athletic training students are expected to respect an injured athlete’s right to privacy. When an injury occurs, do not crowd the athlete. Only one or two athletic training students should assist the staff athletic trainer when necessary. The remaining athletic training students should continue to watch and monitor the practice or game.

It is the responsibility of all personnel within the Athletic Training Department to ensure that all patient information (personal, medical, or education related) remain confidential. Due to the varied number of staff personnel that may be involved with a student-athlete’s case, it is essential that a policy of confidentiality be observed in order to maintain an atmosphere of mutual trust. It is illegal for any personnel to gain access to patient information, through any and all means, unless the information is needed in order to treat the patient, or because their job would require such access.

All AU Athletic Training Department personnel are expected to adhere to the Confidentiality Policy at all times. This policy must be signed at the beginning of each year and a copy will be kept in the athletic training student’s file. Violation of the policy is grounds for dismissal from the AU Athletic Training Department. A copy of Confidentiality Policy can be found later in this manual.

Media Relations:

All relations with the media concerning an injured member of an Alfred University athletic team will be handled by the AU Sports Information Department in consultation with the Team Physician and the Staff Athletic Trainer assigned to a particular sport. At no time are Alfred University Athletic Training Students permitted to talk with members of the working media concerning a member of an AU athletic team.

Medical Records:

1. All medical records are legal and binding documents and should be treated as such.
2. All medical records and medical information about a student-athlete are private and confidential. Anything you see or hear concerning an athlete should remain confidential.
3. It is highly recommended that folders/charts not be taken out to practices. In the event that it is necessary to take the folders/charts out to practices, extreme care must be taken to ensure that the documents do not get dirty, wet, lost, etc. Staff Athletic Trainers reserve the right to forbid taking folders/charts out to practices.
4. At no time are folders/charts to be taken home or to a game!
5. The student-athlete’s medical chart/computer file should be updated on a daily basis using the standard forms and SOAP note format and/or the SportsWare computerized injury surveillance database.

6. The head athletic training student for each sport is responsible for preparing a Daily Coach’s Report for his/her team. This report must be reviewed and countersigned by the faculty/staff athletic trainer responsible for that sport before presenting it to the head coach.

7. All referrals to outside physicians and/or specialists must come from a staff athletic trainer only!

8. All notes MUST be written in **BLUE or BLACK** ink only!

9. Student-athlete medical folders will be organized by color and will be stored according to sport:
   - football .................................................. purple
   - track & field/cross country ......................... green
   - men’s soccer ........................................... blue
   - women’s soccer ...................................... red
   - volleyball .............................................. grey
   - swimming/diving ..................................... red
   - men’s basketball ..................................... yellow
   - softball .................................................. yellow
   - women’s basketball ..................................... red
   - men’s lacrosse .......................................... orange
   - women’s lacrosse ................................. yellow
   - women’s tennis ...................................... grey
   - men’s tennis .......................................... grey

Each individual folder will be arranged in the following manner (most recent year on top):

   - right side-  
     physician authorization  
     exit physical (at end of season)  
     orthopedic exam  
     health history questionnaire  
     medical exam and authorization  
     pre-participation physical exam consent  
     assumption of risk  
     try-out release  
     consent for release of medical information  
     consent to release info to parent/coach  
     heat acclimation questionnaire (fall sports only)  
     nutritional supplement disclosure

   - left side-  **(by injury)**  
     SportsWare treatment records (at end of career)  
     MD prescriptions
All student-athletes will also have a corresponding insurance folder (manila). The insurance folder will be arranged in the following manner:

- Most recent year on top
- Copy of insurance information form; copy of insurance card(s)
TREATMENT AND THERAPEUTIC MODALITY POLICY

Treatment Policy:

1. All student-athletes who require treatment, taping, rehabilitation, etc. must be evaluated by one of the staff athletic trainers and/or team physician before any service can be rendered.

2. If you believe that an injured athlete should be referred to an outside physician and/or specialist, notify a staff athletic trainer and have them make the referral in conjunction with the Team Physician. Athletic training students ARE NOT to independently refer athletes to outside physicians and/or specialists, unless you feel that the injury is an emergency and a staff athletic trainer is not available.

3. If an athlete you are not familiar with comes into the athletic training room for assistance, the following procedures should be followed:
   a) direct the athlete to an athletic training student assigned to his/her sport;
   b) if an athletic training student assigned to his/her sport is not available, refer to the athlete’s chart/folder, re-evaluate the injury as necessary, and assist the athlete as needed;
   c) make sure that you document everything that you do for that athlete and inform the athletic training student and/or staff athletic trainer assigned to that sport as soon as possible;
   d) request assistance from a staff athletic trainer if unsure of how to treat the athlete.

8. Athletes are not allowed to turn on physical therapy modalities or tape themselves (except for wrist circles and bandages for minor/non-infected wounds, etc.). Ask the athlete how you may help them. Athletes who attempt to treat themselves should be immediately informed of the athletic training room policy and one of the staff athletic trainers should be notified if the problem persists.

9. Athletic training students assigned to a particular ACI / sport should update the staff athletic trainer responsible for their sport on a daily basis regarding the progress that each injured athlete is making in their treatment and rehabilitation program.

10. All athletic training students should be familiar with all the policies and procedures located in this handbook and in the athletic training room.
Therapeutic Modality Policy:

1. Therapeutic modalities **may not** be used or operated without a staff athletic trainer present.
2. Athletic training students may not independently use therapeutic modalities to treat student athletes.
3. Once athletic training students have successfully completed the competency check-off for a specific modality, they may use the therapeutic modality under the supervision of a staff athletic trainer.
4. All treatment programs using therapeutic modalities must be approved by a staff athletic trainer before the program is implemented.
5. Athletic training students may not independently change and/or modify therapeutic modality treatment programs.
6. All precautions, warnings, and contraindications for each therapeutic modality must be followed at all times.
7. Proper operating instructions and safety protocols for each therapeutic modality must be followed at all times.
8. If you determine a therapeutic modality is not working properly, do not use the modality and notify a staff athletic trainer as soon as possible. Place a sign on the modality indicating that it is broken and should not be used.
9. Provide the student athlete with a thorough explanation of the treatment procedure, including sensation(s) to be experienced. Tell the student athlete to notify you as soon as possible if they experience any adverse reactions. If you have a question regarding the proper operation of any therapeutic modality, contact a staff athletic trainer before using the modality.
OCCUPATIONAL EXPOSURE TO BLOOD/ BODY FLUID

POLICY: To provide proper follow-up and treatment to all Alfred University Athletic Training Staff and Students who have had an exposure to blood or body fluids at Alfred University or one of its affiliates. The affiliate’s policy will always supersede this policy.

PURPOSE: To prevent the spread of HBV, HCV and HIV from source individual to students and staff. To provide proper treatment and monitoring of all exposures.

This is to include:
1. Immediate treatment - proper cleansing of exposed area
2. Clinical evaluation within one hour of a reported incident of the source risk of Hepatitis B, Hepatitis C and HIV infection and determination of the need for post-exposure prophylaxis (PEP) based on information available at the time of the exposure.
3. When indicated, referral for source serologic tests for Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), and Human Immunodeficiency Virus (HIV).
4. When indicated, the individual exposed will be referred for Hepatitis B immune status, and Hepatitis C and HIV serologic testing.
5. In reference to current published information, chemoprophylaxis will be offered to all staff and students exposed to blood and body fluids who are found to be at risk for Hepatitis B or HIV infection.
6. Chemoprophylaxis drugs will be available from the Saint James Mercy Hospital pharmacy. A 24-hour supply will be maintained in the ER pyxis.

DEFINITION:
Exposure to blood/body fluids is a break in Standard (Universal) Body Substance Isolation with contact of blood or other body fluids (semen, vaginal secretions, internal body fluids, or other body fluid visible amniotic fluid, pericardial fluid, peritoneal fluid, secretions and any body fluid visibly contaminated with blood), through percutaneous inoculation (e.g., needle stick) or contact with an open wound, non-intact skin, or mucous membrane, while performing normal job duties.

Contact of intact skin with one of these body substances generally is not considered a transmission risk. However, if the contact was prolonged or covered an extensive area of skin, it may be prudent to treat the contact as an exposure. Examples of exposure include needle sticks, splashing of blood into face, and contact with vomit or other bodily fluids on mucus membranes.

Transmission of HIV via a human bite is theoretically based on the likelihood of blood-to-blood contact and on the likelihood that the source or recipient is HIV-infected. The following may increase risk for transmission:

a. Biter is HIV infected and breaks the victims skin causing it to bleed, and the biter has bleeding gums or is bleeding from the mouth.
b. Victim is HIV infected and the biter breaks the skin causing it to bleed and blood enters the biters mouth.
RESPONSIBILITY:

1. The Head Athletic Trainer is responsible to:
   a. Provide immediate treatment for exposure.
   b. Gather information regarding the exposure.
   c. Facilitate, if possible and with that person’s permission, any testing of the individual whom the student or staff was exposed to.
   d. Provide general information on Hepatitis B, Hepatitis C and HIV when indicated.
   e. Provide general information on chemoprophylaxis when appropriate.
   f. Provide follow-up on all occupational exposures.
   g. Provide referral for follow-up with Team Physician or Saint James Express Care/Emergency Room if appropriate.

2. In the absence of the Head Athletic Trainer or Express Care, the supervising certified staff would be responsible to:
   a. Provide immediate treatment for exposure.
   e. Gather information regarding the exposure.
   f. Facilitate, if possible and with that person’s permission, any testing of the individual whom the student or staff was exposed to.
   g. Provide general information on Hepatitis B, Hepatitis C and HIV when indicated.
   d. Provide general information on chemoprophylaxis when appropriate.
   g. Provide referral for follow-up with Team Physician or Saint James Express Care/Emergency Room if appropriate.

3. The Team Physician/Express Care/Emergency Room will make the decision in consultation with the individual regarding the need for chemoprophylaxis. They will also be responsible for obtaining any serological testing and prescription writing. A physician or trained counselor will also provide HIV pretest counseling if deemed necessary by the exposure.

4. Chemoprophylaxis drugs and testing will be made available to all staff and students based on their exposure risk. The testing and prescriptions are available 24-hours a day at Saint James Mercy Hospital.
EXPOSURE PROCEDURE:

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| Student/Staff       | 1. Cleanses exposed area immediately and thoroughly.  
|                     | a. Wounds and sites of non-intact skin: Washes area immediately with soap and water. A skin antiseptic (e.g. betadine, alcohol) may be used if otherwise not contraindicated. Do not use bleach or other environmental disinfectants. Vigorous disruption of the skin should be avoided.  
|                     | b. Eye/conjunctival splash: irrigate with copious amount of water or sterile saline for minimum 15 seconds.  
|                     | c. Mouth: rinse well with water or 3% hydrogen peroxide and water.  
|                     | 2. Completes Incident Report.  
|                     | 3. Notifies supervisors IMMEDIATELY.  
|                     | i. Head Athletic Trainer or  
|                     | ii. Other Certified Staff Member |

NOTE: Follow-up with Head Athletic Trainer is MANDATORY as soon as possible after exposure. After treatment has been initiated, there also must be written notification describing the incident to the Head Athletic Trainer and Program Director.

Supervisor:
1. Documents actions taken.
2. Helps facilitate information regarding the type of exposure, substance exposed to, quality and duration of exposure, and source risk factors.
3. Helps facilitate serological testing of exposing individual. It is NOT the exposed individual’s responsibility to ask the other person to be tested (i.e. HIV, Hepatitis B and C), rather it is the responsibility of the supervisor to help facilitate this collection of blood.
4. The exposed individual will be referred immediately to the Head Athletic Trainer and Team Physician, if available, for evaluation, documentation, and possible testing and treatment as determined by the team physician. If the Team Physician is unavailable or circumstances warrant more immediate care, the Head Athletic Trainer will refer the exposed individual to the Crandall Student Health Center or Saint James Mercy Hospital Emergency Room.
5. Sends Incident Report to Student Health.
6. Records on OSHA report if indicated.
7. Sets up exposure retraining session with the Team Physician if repeated exposure or if indicated.

EDUCATION ABOUT BLOOD BORNE PATHOGENS

Athletic training students are educated with regards to OSHA blood borne pathogens in two courses of study in the athletic training curriculum. The first course is PE 311 – First Aid and CPR. This is the student’s first exposure to athletic training and encompasses an overview of the OSHA standards and how they relate to the practice of athletic training.

The second course is ATT 403 – Medical Aspects of Athletic Training. This course is taught by Dr. Daniel Curtin. Dr. Curtin serves not only as the Team Physician for Alfred University but as the Chairperson of the Infectious Disease Committee at Saint James Mercy
Dr. Curtin is well versed in the 2001 OSHA revised Blood Borne Pathogens Standard 1910.1030. Regular class attendance is expected of all students. Faculty members shall establish their own regulation governing attendance and communicate such to the students, however students need to complete this coursework in the OSHA standards before beginning their clinical experiences.

Certified staff members are expected to have completed a course in the OSHA standard prior to their hire as staff. The Head Athletic Trainer and Program Director will review their transcripts prior to hire to make sure that this is done.

Each student athletic trainer and certified staff also attends the Blood Borne Pathogen Lecture during the preseason Student Athletic Training orientation each school year. Each student athletic trainer will be made aware of the potential risk for infection associated with providing athletic training services, as well as the measures that can be taken to prevent the risk of blood borne pathogen transmission. Attendance records will be maintained in the Program Directors office.

REFERENCES:

US Department of Health and Human Services 1990 Guidelines. Post exposure prophylaxis for hepatitis B and management of persons after occupational exposures that may place them at risk of acquiring HIV infection, MMWR 1/26/90 and 2/2/90.


OSHA. Occupational exposure to bloodborne pathogens; final Rule 29 CFR part 1910.1030.


Saint James Mercy Hospital Infectious Disease Control Committee Guidelines.
POLICIES FOR THE PROTECTION AGAINST BLOODBORNE PATHOGENS

Through the normal course of providing athletic training services, staff and student athletic trainers may come in contact with bodily fluids, which may pose a risk for infection from blood borne diseases. Universal precautions should be utilized whenever you suspect bodily fluids to be present. These diseases may include Hepatitis B, HIV, or other blood borne pathogens. It is essential that the staff and student athletic trainer utilize the following techniques and principles to minimize the risk of pathogen transmission:

1. Treat all bodily fluids as infectious
2. Use disposable latex gloves when treating a student athlete who is bleeding or has breaks in the skin allowing the discharge of bodily fluids
3. Wash hands before and after every treatment
4. Use protective devices during procedures where bodily fluids are likely to be discharged
5. Use resuscitation masks during CPR and Rescue Breathing
6. Dispose of all contaminated waste in approved biohazard containers
7. Biohazard containers will be disposed of by incineration at Saint James Mercy Hospital, Inc, a licensed agency
8. Use of a fresh 1:10 bleach solution or other OSHA approved cleaners for cleaning all bodily fluid spills

BIOHAZARDOUS EXPOSURE DURING PHYSICAL ACTIVITY AND GAMES

Blood during physical activity and games shall be handled utilizing the following additional guidelines:

1. All open wounds and/or breaks in the skin are to be fully covered by a bandage before allowing the athlete to return to participation. The Athletic Trainer shall assess the feasibility of dressing the wound on the field. If this is not feasible, the athlete shall be removed from the field to the sidelines or athletic training facility where it can be appropriately cleaned and covered.
2. If an athlete's uniform is grossly soiled with blood or other bodily fluid, the athlete shall be removed from participation and the uniform changed prior to return to participation.
3. Any article of clothing that has been saturated with blood or other bodily fluids shall be disinfected by washing separately from other uniforms and washed in a 10% bleach solution.

SPILL CLEAN UP

The athletic training students and staff will be the primary individuals responsible for the clean up of all bodily fluid spills within the athletic environment. Clean up will be done in a manner consistent with the universal precautions described above.
MANAGEMENT OF ATHLETIC TRAINING STAFF & STUDENTS WITH / EXPOSURE TO COMMUNICABLE/INFECTIONOUS DISEASES

Active Communicable Disease Policy

PURPOSE: To prevent the transmission of disease from the staff/student to athletes, the athletes to the staff/student, and/or staff/student to staff/student. Athletic Training Students who have signs and symptoms of transmissible infectious disease must report promptly to the Head Athletic Trainer and then to Student Health who will refer them for proper care. Athletic Training Staff who have signs and symptoms of transmissible infectious disease must report promptly to the Head Athletic Trainer/Team Physician and then to their own physician if necessary.

Athletic Training Staff and Students who are exposed to occupational communicable/infectious diseases will be notified and handled according to the Communicable/Infectious Disease Policy. The Head Athletic Trainer and/or Team Physician may restrict students or staff from duty and approve their return to work according to the Communicable/Infectious Disease Policy guidelines.

Definitions:

Food Preparation: Involves contact with any food item or beverage, including water bottles, and Gatorade.

Patient Care: Any care of any athletes, students, staff, spectators, or other individuals while acting in the capacity as an athletic training student or staff member.
DISEASE/PROBLEM - RECOMMENDATIONS

AIDS/HIV
Personal: Relieve from direct patient contact if presence of exudative lesions or weeping dermatitis or evidence of any of the following infections that require restrictions until acute condition resolves. The student’s/staff’s own personal physician should be involved regarding work-related decisions. Partial restriction: Wear gloves for direct contact with mucous membrane or non-intact skin of all patients. Evaluation of each case must be made by a combination of the Head Athletic Trainer, Medical Director of the University, the Team Physician, Program Director, and the student’s/staff’s own physician. The student/staff must be counseled concerning proper precautions.

Action after exposure: Follow "Occupational Exposure to Blood/Body Fluid Policies and Procedures".

Conjunctivitis
Allergic: No restrictions.

Bacterial: In outbreak settings where conjunctivitis is being spread, symptomatic personnel must be restricted from providing care and preferably removed from the environment. Relieve from direct patient care until discharge ceases. Needs to complete antibiotic treatment as directed.

Viral: In outbreak settings where conjunctivitis is being spread, symptomatic personnel must be restricted from providing care and preferably removed from the environment. Emphasize good hand washing. Individual should not work with immunocompromised patients, or in ophthalmology settings.

Cytomegalovirus (CMV):
No work restrictions unless clinically indicated.

Dermatitis:
Workers with weeping dermatitis on body areas that may contact patients should be removed from direct patient care and/or contact with patient care equipment until the condition resolves.

Diarrhea
Acute stage: Exclude from direct patient care and food preparation until symptoms resolve unless the diarrhea is determined non-infectious. (See specific agent if diagnosed). Campylobacter: Reinforce good hygiene practices; should not work with infants or immunocompromised patients until 2 negative stools have been obtained.

Salmonella:
Reinforce good hygiene practices; should not work with infants, immunocompromised patients, or be involved with food handling until 2 negative stools have been obtained taken not less than one week after onset and not less than 24 hours apart. Relieve from direct patient contact until stool is free of the (typhoid) infecting organism on 2 consecutive cultures obtained not less than 24 hours apart, 48 hours after antibiotics.

**Shigella:**
Relieve from direct patient contact until 2 negative stools have been obtained taken not less than 1 week after onset and not less than 24 hours apart.

**Yersinia:**
Reinforce good hygiene practices; should not work with infants or immunocompromised patients until 2 negative stools have been obtained.

**Enteroviral:**
Reinforce good hygiene practices; should not work with infants or immunocompromised patients until symptoms resolve.

**Fifth disease (Parvovirus B19):**
Respiratory secretions can harbor the virus for 4-15 days before the appearance of rash. Remove from work symptomatic individuals with suspected Parvovirus B19 exposure that work in high risk areas until the appearance of rash or until symptoms resolve.

**Group A Streptococcal (including Strep throat):**
Relieve from direct patient contact until 24 hours after adequate treatment is started. Since Group A streptococcal surgical wound infections occur infrequently, the occurrence of a single case will prompt a search for a carrier. If personnel are linked epidemiologically to the occurrence of disease, they should be cultured, and if positive, removed from patient contact until carriage is eradicated.

**Group B Streptococcal:**
Carriage by personnel does not appear to be important in nosocomial transmission. Careful hand washing by personnel will minimize the risk of nosocomial spread.

**Hepatitis, Viral:**
Personnel

**Hepatitis A:** Relieve from direct patient care until 7 days after onset of jaundice. Food handlers: Must notify NYSDOH for appropriate guidance and follow-up.

**Hepatitis B:** Acute: Reinforce recommended precautions and injury prevention techniques during procedures that involve trauma to tissues or contact with mucous membranes or non-intact skin. Individual should remain off work while clinically ill. Individuals with weeping dermatitis: restrict from patient care and contact with patient care equipment until the condition resolves.
Hepatitis C, Acute: Reinforce recommended precautions and injury prevention techniques during procedures that involve trauma to tissues or contact with mucous membranes or non-intact skin. Individual should remain off work while clinically ill.

Hepatitis B and C, Chronic:
Chronic carriers should be evaluated for infection risk by a combination of the Head Athletic Trainer, Medical Director of the University, the Team Physician, Program Director, and the student’s own physician. Mutifactorial criteria should be used to determine whether the worker poses a significant risk to patients taking into consideration any evidence that the worker is unable or unwilling to follow infection control recommendations, is epidemiologically linked to cases of transmission in patients, or is too ill to work. All Students/Staff who are HBsAg and HC positive will be counseled regarding their infectivity and instructed to routinely take steps which will prevent injury that could result in blood contamination.

Occupational exposure: Follow "Occupational Exposure to Blood/Body Fluid Policy and Procedure"

Herpes Simplex

Hands/fingers (Herpetic whitlow): Relieve from direct patient contact until lesions heal. It is not known whether gloves prevent transmission.

Orofacial: Personnel should not care for infants or immunocompromised patients until lesions heal. Lesions should be covered with an appropriate barrier, i.e., dressing, mask.

Genital: No work restrictions; reinforce good hygiene practices.

Lice

Personnel: Relieve from direct patient contact until treated.

Occupational exposure: Staff/students who contact patients with lice do not require treatment unless evidence of infestation is present.

Measles
Confirmed or suspected: Remove from workplace until 5 days after the rash appears or until active disease is ruled out.

Post-exposure (non-immune personnel): Remove from workplace from the 7th through 21st day after exposure and/or 5 days after rash appears.

Meningococcal
Occupational exposure: Consult with Infection Control Chairman.
Disease: Those employees with close exposure (ex. fundoscopy, assisting patient vomiting, mouth to mouth resuscitation) will be treated with Rifampin.

Mumps (Parotitis):
Confirmed or suspected: Relieve from workplace until 9 days after onset of parotitis or until active disease is ruled out.

Post-exposure (non-immune personnel with very close contact): Relieve from workplace from the 12th through the 26th day after exposure or until 9 days after onset of parotitis.

Parvovirus B19:
See Fifth Disease.

Pertussis:
Confirmed or suspected: Remove from workplace until the third week after onset of cough or until 5 days after start of effective therapy or active disease is ruled out.

Post-exposure (susceptible personnel with very close contact): No work restrictions, but 2 weeks of erythromycin prophylaxis should be given to close contacts.

Rubella:
Confirmed or suspected: Remove from workplace until 5 days after the rash appears or until active disease is ruled out.

Post-exposure (non-immune personnel): Remove from workplace from the 7th through 21st day after exposure and/or 5 days after rash appears.

Scabies:
Personnel: Relieve from direct patient contact until treated.

Occupational exposure: Both symptomatic and exposed asymptomatic students/staff (direct skin to skin contact) should be treated with Elimite.

Staphylococcus Aureus skin lesions:
Relieve from direct patient contact until lesions have resolved.

Tuberculosis
Active pulmonary or laryngeal tuberculosis:
Personnel: Remove from workplace until effective therapy has been instituted and sputum cultures are negative.

Occupational exposure: Referral to Team Physician for appropriate follow-up.

Positive PPD: No work restrictions. Rule out active disease and consider INH prophylaxis.

Upper respiratory infections:
It is preferred that persons with acute respiratory infections not provide direct patient care. Supervisory discretion is advised as staffing limitations and severity of symptoms may affect this decision. Prevent contact with patients who are at increased risk for
complications from a respiratory infection (i.e., immunocompromised, underlying respiratory disease). Meticulous hand washing after contact with oral/nasal secretions is necessary.

**Varicella (chickenpox):**

Active: Remove from workplace until all lesions are dry and crusted.

Post-exposure: Follow "Exposure to Chicken Pox" Policy.

**Varicella Zoster (Shingles):**

Active - localized: Use of appropriate barrier desirable: personnel should not care for infants or immunocompromised patients until lesions are dry and crusted.

Active - disseminated: Remove from workplace until lesions are dry and crusted.

Post-exposure (non-immune personnel): Follow "Exposure to Chicken Pox" Policy.

Reference:

Subject: Recommendations for the management of communicable diseases among employees in health care facilities.

NYSDOH health facilities series memorandum: 96-14 9/3/96  
Subject: Control of scabies in health care facilities

APIC curriculum for infection control practice
**Hepatitis B Vaccine Information Sheet**

The Disease:

Hepatitis B is a viral infection caused by hepatitis B virus (HBV), which causes death in 1-2% of patients. Most people with hepatitis B recover completely, but approximately 5-10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. Some may develop chronic active hepatitis and cirrhosis. HBV also appears to be a causative factor in the development of liver cancer. Thus, immunization against hepatitis B can prevent acute hepatitis and also reduce sickness and death from chronic active hepatitis, cirrhosis, and liver cancer.

The Vaccine:

RECOMBIVAX® HB (Hepatitis B Vaccine Recombinant) is a non-infectious subunit viral vaccine derived from hepatitis B surface antigen (HbsAG) produced in yeast cells. A portion of the hepatitis B virus gene, coding for HbsAG, is cloned into yeast, and the vaccine for hepatitis B is produced from cultures of this recombinant yeast strain according to methods developed in the Merck, Sharp, & Dohme Research Laboratories. The Vaccine against hepatitis B, prepared from recombinant yeast cultures, is free of association with human blood or blood products. Each lot of hepatitis B vaccine is tested for safety and sterility.

A high percentage of healthy people who receive two doses of vaccine and a booster achieve high levels of surface antibody (anti-HBs) and protection against hepatitis B. Persons with immune-system abnormalities, such as dialysis patients, have less response to the vaccine, but over half of those receiving it do develop antibodies. Full immunization requires three (3) doses of vaccine over a six month period although some persons may not develop immunity even after three (3) doses. There is no evidence that the vaccine has ever caused hepatitis B. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop clinical hepatitis in spite of immunization. The duration of immunity is unknown at this time.

Possible Vaccine Side Effects:

The incidence of side effects is very low. No serious side effects have been reported with the vaccine. A few persons experience tenderness and redness at the site of injection. Low grade fever may also occur. Rash, nausea, joint pain, and mild fatigue have also been reported. The possibility exists that more serious side effects may be identified with more extensive use.

Due to the inherent nature and risk of the job, the Alfred University Division of Athletic Training recommends that all staff athletic trainers and athletic training students receive this vaccine.
**Hepatitis B Vaccine Declaration / Declination**

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<th>First Name</th>
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**Complete and Sign Section A or Section B Below:**

**Section A**

I have been informed about Hepatitis B Vaccination by reading the information provided with this waiver. I understand its role in providing protection for persons (i.e. health care personnel, etc.) who are at increased risk for Hepatitis B though clinical exposure. I understand the risks and benefits of being vaccinated and not being vaccinated. In addition, I understand that it is my responsibility to immediately report any adverse reaction to the vaccination. I also realized that I am financially responsible for the series of three (3) shots.

- [ ] YES, I choose to receive this Hepatitis B Vaccine (RECOMBIVAX®).

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**Section B**

I understand that due to my potential occupational exposure to blood or other infectious materials, I may be at risk of acquiring Hepatitis B (HBV) infection. I decline Hepatitis B vaccination at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

- [ ] NO, I do not choose to receive this Hepatitis B Vaccine (RECOMBIVAX®) at this time.

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VARICELLA ZOSTER PROCEDURES AND IMMUNIZATION GUIDELINES

PURPOSE: To minimize the risk of chickenpox (Varicella) to staff, students, and athletes

A. Eligibility: All Athletic Training Students and Staff will be screened for a history of chickenpox on hire and on each update as needed.

1. Positive history: Individuals who give a positive history of chickenpox are considered immune and no further action is needed.

2. Negative history: If the individual has no recalled history of chickenpox, the individual will be strongly recommended and advised to have a titer drawn. If titer is positive the person is considered immune. If negative, the person is susceptible to chickenpox. Varivax vaccine will be offered through the Crandall Student Health Center at the individual’s own cost. Financial consideration will be given for those in need. ALL exposures to Varicella (chickenpox or zoster) whether at home or work must be reported to the Head Athletic Trainer.

B. Vaccine: Varivax (Varicella Virus Vaccine Live) (Oka Merck)

C. Vaccine efficacy: Responses in adolescents and adults with the above schedule showed a seroconversion rate of 94-99%. Since Varivax induces detectable antibody in this high proportion of individuals, post vaccine screening is not recommended. At the present time there is no recommendation for periodic boosters.

D. Vaccine transmissibility: Persons vaccinated with Varivax may potentially be capable of transmitting the live virus in the vaccine to close contacts. However, transmission in this way has not been documented, and transmission would not be expected to occur in any case unless the vaccinee was to develop a chickenpox-like rash. Thus transmission of the vaccine virus to a susceptible (non-immune), high-risk individual (e.g., newborns, pregnant women, immunocompromised persons) from vaccinee is theoretically possible but highly improbable. In addition, transmission of vaccine virus to a high-risk person, were it to occur, should not result in significant illness. Individuals who have received Varivax are not restricted from caring for patients in high-risk groups for Varicella, (newborns, non-immune pregnant women, immunocompromised patients) unless a rash develops. Vaccine recipients who develop a rash during the 6 weeks after vaccination should be evaluated at the Student Health Center or by their own physician, and may return to work only after receiving clearance to do so.
II. POSTEXPOSURE PROTOCOL

A. Definition: Exposure time frame begins two days before the contact developed the chickenpox rash. Concern about the exposed individual exposing patients occurs from day 10 to day 21 from the first day of individual exposure. The exposed individual must be evaluated within 10 days from the first day of the exposure.

B. Exposed individual with a negative history and/or negative titer will have the titer repeated only if there has been an additional exposure since the last titer.

C. If current titer (no history of Varivax vaccination) is negative:
   1. The individual will be evaluated to determine the level of patient contact, and may be reassigned to a low-risk area on the advice of the Head Athletic Trainer and Team Physician.
   2. The exposed individual will remain away from patient contact for the maximum incubation period of chickenpox beginning on the 10th day after exposure until the 21st day after exposure. Individuals are considered exposed from 2 days prior to the onset of rash in family members or other contact.
   3. If illness does not develop by 21 days, the individual is no longer excused and returns to work (including patient contact) at that time. Varivax should be initiated.
   4. If chickenpox develops, the individual will remain at home at least 5 days from the onset of lesions until all the lesions have dried and crusted.

D. Work restrictions of previously vaccinated (with Varivax) individual exposed to chickenpox: Varivax vaccine does not provide complete protection against chickenpox. Persons previously susceptible to chickenpox may still develop chickenpox after receiving the vaccine. However the seroconversion rates are so high that testing after immunization is unnecessary.

   It is the responsibility of the individual to report any exposure to the Head Athletic Trainer. The individual must report immediately if they develop any signs or symptoms suggestive of chickenpox (fever, rash).
Blood-borne pathogens are disease-causing microorganisms that can be potentially transmitted through blood contact. The bloodborne pathogens of concern include (but are not limited to) the hepatitis B virus (HBV) and the human immunodeficiency virus (HIV). Infections with these (HBV, HIV) viruses have increased throughout the last decade among all portions of the general population. These diseases have potential for catastrophic health consequences. Knowledge and awareness of appropriate preventive strategies are essential for all members of society, including student-athletes. The particular blood-borne pathogens HBV and HIV are transmitted through sexual contact (heterosexual and homosexual), direct contact with infected blood or blood components, and perinatally from mother to baby. In addition, behaviors such as body piercing and tattoos may place student-athletes at some increased risk for contracting HBV, HIV or Hepatitis.

The emphasis for the student-athlete and the athletics health-care team should be placed predominately on education and concern about these traditional routes of transmission from behaviors off the athletics field. Experts have concurred that the risk of transmission on the athletics field is minimal.

**Hepatitis B Virus (HBV)**

HBV is a blood-borne pathogen that can cause infection of the liver. Many of those infected will have no symptoms or a mild flu-like illness. One-third will have severe hepatitis, which will cause the death of one percent of that group. Approximately 300,000 cases of acute HBV infection occur in the United States every year, mostly in adults. Five to 10 percent of acutely infected adults become chronically infected with the virus (HBV carriers). Currently in the United States there are approximately one million chronic carriers. Chronic complications of HBV infection include cirrhosis of the liver and liver cancer. Individuals at the greatest risk for becoming infected include those practicing risky behaviors of having unprotected sexual intercourse or sharing intravenous (IV) needles in any form. There is also evidence that household contacts with chronic HBV carriers can lead to infection without having had...
sexual intercourse or sharing of IV needles. These rare instances probably occur when the virus is transmitted through unrecognized-wound or mucous-membrane exposure. The incidence of HBV in student athletes is presumably low, but those participating in risky behavior off the athletics field have an increased likelihood of infection (just as in the case of HIV). An effective vaccine to prevent HBV is available and recommended for all college students by the American College Health Association. Numerous other groups have recognized the potential benefits of universal vaccination of the entire adolescent and young-adult population.

**HIV (AIDS Virus)**

The Acquired Immunodeficiency Syndrome (AIDS) is caused by the human immunodeficiency virus (HIV), which infects cells of the immune system and other tissues, such as the brain. Some of those infected with HIV will remain asymptomatic for many years. Others will more rapidly develop manifestations of HIV disease (i.e., AIDS). Some experts believe virtually all persons infected with HIV eventually will develop AIDS and that AIDS is uniformly fatal. In the United States, adolescents are at special risk for HIV infection. This age group is one of the fastest growing groups of new HIV infections. Approximately 14 percent of all new HIV infections occur in persons aged between 12 to 24 years. The risk of infection is increased