Severna Park High School Emergency Action plan for medical conditions and emergency procedures 2022-2023

Introduction

Emergency situations may arise at any time during athletic events. Expedient action must be taken in order to provide the best possible care to the sport participant of emergency and/or life threatening conditions. The development and implementation of an emergency plan will help ensure that the best care will be provided.

As emergencies may occur at any time and during any activity, the athletic department and school personnel must be prepared. This preparation involves formulation of an emergency plan, proper coverage of events, maintenance of appropriate emergency equipment and supplies, utilization of appropriate emergency medical personnel, and continuing education in the area of emergency medicine and yearly rehearsal.

Components of the Sports Medicine Procedures and Protocols

1. Emergency Plan Personnel
2. Roles of First Responders
3. Emergency Communication
4. Emergency Equipment
5. Medical Emergency Transportation
6. Non-Medical Emergencies Protocols
7. Standard Protocols

Appendix A:	Spine Injury Protocol
Appendix B:	Sudden Cardiac Arrest Protocol
Appendix C:	Concussion Protocol
Appendix D:	Asthma Protocol
Appendix E:	Diabetic and Insulin Shock Protocol
Appendix F:	Environmental Heat Illness
Appendix G:	Environmental Cold Injury
Appendix H:	Lightning Policy
Appendix I:	Psychosocial Intervention
Appendix J:	COVID-19 Considerations

1: Emergency Plan Personnel

During official athletic practices and competitions, the first responder to an emergency situation is typically a member of the athletic training staff, or coach. At all practices and events, one or more members of the coaching staff will be present and should be prepared to act as first responders. A team physician is present at home football competitions. The type and degree of sports medicine coverage for an athletic event or practice may vary widely, based on such factors as the sport or activity, the setting, and the type of training or competition. Certification in cardiopulmonary resuscitation (CPR), AED use, and first aid is required for all coaches as per NCAA and WIAA regulation; education also provided will include prevention of disease transmission and emergency plan review. Other athletics personnel associated with practices, competitions, skills instruction, and strength and conditioning are strongly recommended to complete this training.

During away events the host school or organization's emergency plan should be followed if available. **If not available, follow this EAP**. The appropriate athletic training, medical and administrative staff at the school should be notified of a medical emergency that occurred off campus as soon as is feasible.

2: Roles of the First Responders

The emergency team may consist of a number of healthcare providers including physicians, emergency medical technicians (EMT), certified athletic trainers (ATC) and School Nurses. The emergency team may also consist of school personnel such as athletic directors (AD), Assistant principals, coaches, sports medicine students (SMS), team managers, and possibly bystanders. Roles of these individuals within the emergency team may vary depending on various factors such as the number of members of the team, the athletic venue itself, or the preference of the head athletic trainer.

Roles within the Emergency Team

1. **Establish scene safety and immediate care of the athlete**

    1. The first and most important role is establishing safety of the scene and immediate care of the athlete. Acute care in an emergency situation should be provided by the most qualified individual on the scene. **Individuals with lower credentials should yield to those with more appropriate training.**

2. **Activation of the Emergency Medical System and campus security**

    1. The second role, EMS activation, may be necessary in situations where emergency transportation is not already present at the sporting event. This should be done as soon as the situation is deemed an emergency or a life-threatening event. Time is the most critical factor under emergency conditions. Activating the EMS system may be done by anyone on the team. However, the person chosen for this duty should be someone who is calm under pressure and who communicates well over the telephone. This person should also be familiar with the location and address of the sporting event and directions to the facility as specified in this document.

Activating the EMS System - Making the Call:

• 911 (9-911 if from a school line)

• Notify the appropriate administration if not already aware: including athletic director or principal

Providing Information*:*

• N*ame, address, telephone* number of caller

• Nature of emergency, whether medical or non-medical

• Number of athletes

• Condition of athlete(s)

• First aid treatment initiated by first responder

• Specific directions as needed to locate the emergency scene

• Other information as requested by dispatcher

3. **Emergency equipment retrieval**

    1. The third role, equipment retrieval, may be done by anyone on the emergency team who is familiar with the types and location of the specific equipment needed.

4. **Direction of EMS to scene**

    1. The fourth role of the emergency team is that of directing EMS to the scene. One member of the team should be responsible for meeting emergency medical personnel as they arrive at the site of the emergency. Depending on ease of access, **this person should have keys to any locked gates or doors** that may slow the arrival of medical personnel. SMS or a coach may be appropriate for this role.

* *if non-emergency refer to the standard procedures for medical conditions in the appendices.*

When forming the emergency team, it is important to adapt the team to each situation or sport. It may also be advantageous to have more than one individual assigned to each role. This allows the emergency team to function even though certain members may not always be present. When the nature of an incident is such that requires ongoing monitoring of student health and safety is a concern, the incident command system of the school will be instituted. Pregame "time-outs" should be implemented with the medical staff and coaches to establish what each member of the emergency team will be performing in such an event.

3: Emergency Communication

Communication is the key to quick emergency response. Athletic department staff and emergency medical personnel must work together to provide the best emergency response possible, and should have contact information established as a part of pre-planning for emergency situations. Communication prior to the event is a good way to establish boundaries and to build rapport between groups of professionals. If emergency medical transportation is not available on site during a particular sporting event then direct communication with the emergency medical system at the time of injury or illness is necessary (911 or 9-911). Access to a working telephone or other telecommunications device, whether fixed or mobile, should be assured. The communications system should be checked prior to each practice or competition to ensure proper working order. A back-up communication plan should be in effect should there be failure of the primary communication system. Cellular phone is the preferred method of communication if available. At any athletic venue, whether home or away, it is important to know the location of a workable telephone. Pre-arranged access to the phone should be established if it is not easily accessible.

Emergency Contact Information

Name	Title	Cell	Office
Clayton Culp	District Athletic Director		410-222-5463
Mikaela Flanagan	Pivot	410-599-2160	
Patrick Bathras	Principal		410-544-0900
Dave Kauffman	Athletic Director	410-991-6664	
Barbara McSherry	Nurse	nurse2013@aacps.org	

Guidelines for communication of injuries and emergency situations:

1. Notify the Appropriate Athletic Trainer, ATC will notify the athletic director

2. Notify Athletic Director and/or Principal if ATC cannot be reached in a reasonable amount of time.

    - AD will notify other appropriate institutional personnel as necessary as determined in their EAP.

3. An athletic department point person will be established. This is normally the AD or ATC

    - The point person will also notify and update athlete emergency contact.
    - The point person will ensure that all appropriate athletic and administrative staff are notified and updated.

4. An athletic staff member will be assigned to assist family members upon arrival.

5. The AD or principal will coordinate a media plan. There will be no contact with the media as per media protocol.

6. Appropriate personnel should meet with teammates to discuss the situation and debrief.

7. Appropriate counseling staff should be involved.

8. All involved individuals will document the events. Records will be kept in the athletic director's office. ATC staff will keep medical records with them. All materials used will be collected and kept secure.

4: Emergency Equipment

All necessary emergency equipment should be at or near the site and quickly accessible. Medical personnel and coaches should be familiar with the function and operation of each type of emergency equipment. Equipment should be in good operating condition, and coaching personnel must be trained in advance to use it properly. Emergency equipment should be checked on a regular basis and its use rehearsed by personnel annually. The emergency equipment available should be ***appropriate for the level of training*** for the first responders. It is important to know the proper way to care for and store the equipment as well. Equipment should be stored in an area for easy access

5: Medical Emergency Transportation

EMS may on site during varsity football games. It may also be at other special events such as major tournaments or championship events. Consideration is given to the capabilities of transportation service available (i.e., Basic Life Support or Advanced Life Support) and the equipment and level of trained personnel on board the response unit. In the event that an ambulance is on site, there should be a designated location with rapid access to the site and a cleared route for entering/exiting the venue.

In the medical emergency evaluation, the primary survey assists the emergency care provider in identifying emergencies requiring critical intervention and in determining transport decisions. In an emergency situation, the athlete should be transported by ambulance, where the necessary staff and equipment is available to deliver appropriate care. Emergency care providers should refrain from transporting unstable athletes in inappropriate vehicles. **Any emergency situations where there is impairment in level of consciousness, airway, breathing, or circulation or there is neurovascular compromise should be considered a "*load and go*" situation and emphasis placed on rapid evaluation, treatment and transportation.**

Local Fire Department Coverages

Anne Arundel County Fire Department
8501 Veterans Highway Millersville 21108

Local Emergency Room Departments

Depending on the severity and type of injury, EMS will determine the best emergency room based off of its trauma level.

Hospital	Address	General Phone
Anne Arundel Medical Center	2001 Medical Parkway, Annapolis, MD 21401	443-481-1000
Baltimore Washington Medical Center	301 Hospital Drive, Glen Burnie, MD 21061	410-787-4000
Johns Hopkins Hospital	1800 Orleans Street, Baltimore, MD 21287	410-955-5000

Other Non-Medical Emergencies

For non-medical emergencies, such as fire, bomb threats, severe weather and violent or criminal behavior, refer to the emergency action plan posted in the nearest building and notify police.

Return to Play for Orthopedic Athletic Injuries

It is the responsibility of the medical team to return athletes back to activity safely without risk of further injury. The physician and the athletic trainer are the only personnel permitted to return an athlete back to play and is at the discretion of the ATC on site. Athletes participating without medical clearance should be reported to the medical team by coaches. All athletes that have been seen by their physician needs to present a copy of their return to play note to the coach, as well as the ATC on site.

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 personnel. The emergency plan should be reviewed at least once a year with all athletic personnel, along with CPR, AED and first aid refresher training. Through development and implementation of the emergency plan, the athletic department helps ensure that the athlete will have the best care provided when an emergency situation does arise.

Approved by

Athletic Trainer (SMS or School ATC)	Athletic Director
_____	_____

Appendix A

Athletic Training

Suspected Spinal Injury Protocol

General Guidelines

1. Any athlete suspected of having a spinal injury should not be moved and should be managed as though a spinal injury exists. C-spine in-line stabilization should be maintained.
2. The athlete's level of consciousness (AVPU), circulation, airway, breathing, and neurological status should be assessed. If airway is impaired, maintain c-spine in-line stabilization simultaneously with airway opening using a modified jaw thrust maneuver.
3. EMS should be activated.
4. The athlete should not be moved until immobilized unless absolutely essential to maintain airway, breathing and circulation. If the athlete must be moved, the athlete should be placed in a supine position while maintaining spinal immobilization.
5. In a situation where it may not be appropriate for on-site medical personnel to transfer the athlete to a long spine board prior to EMS arrival (lack of enough qualified help or other factors), the rescuer(s) should maintain in-line stabilization, place a rigid cervical collar on (if possible), and continue to monitor baseline vital signs and complete secondary evaluation while awaiting EMS.

Spine Immobilization

1. If possible, a correctly sized rigid cervical collar should be placed on the athlete prior to moving.
2. When moving a suspected spine-injured athlete, the head and trunk should be moved as a unit by securing the athlete to a long spine board. At minimum three (3) rescuers with preferably five to six (5-6) should be in place to perform the necessary maneuver/technique for the situation.
3. The rescuer controlling c-spine stabilization will be in command of the log roll maneuver and long spine board immobilization. C-spine stabilization can include pack and fill technique and/or static stabilization.
4. Once positioned onto a long spine board, the athlete's should be secured using spider straps. The chest and hips are secured first followed by the lower extremities. The athlete's arms should be left free from long spine board straps to facilitate vital sign monitoring and IV access. Athlete's wrists may be secured together in front of the body with a velcro strap or tape once secured to long spine board.
5. Once torso and legs are secured, the head should be secured last. If necessary, padding should be applied under the athlete's head to fill any voids and maintain neutral in-line position. The head should be secured with lateral restraint pads and then secured to the board with tape over forehead and at the chin.
6. Following securing the athlete to board, 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 history.

8. Athlete should be transported to the most appropriate emergency medical facility and appropriate personnel notified (see Section 5 Emergency Transportations).

Additional 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 (FM Extractor, cordless electric screwdriver) should be readily accessible.
2. All loop straps of the facemask should be cut and the facemask removed from the helmet, rather than being retracted.
3. The **football helmet and chin strap should only be removed if:** 1) the helmet and chin strap do not hold the head securely, such that immobilization of the helmet does not immobilize the head; 2) the design of the helmet and chin strap is such that, even after removal of the facemask, the airway cannot be controlled nor ventilation provided; 3) the facemask cannot be removed after a reasonable period of time; or 4) the helmet prevents immobilization for transportation in an appropriate manner.
4. Should either the helmet or shoulder pads be removed – or if only one of these is present- appropriate spinal alignment must be maintained If the helmet must be removed, spinal immobilization must be maintained while removing. In most circumstances, it may be helpful to remove cheek padding and/or deflate air padding prior to helmet removal.
5. Shoulder pads do not necessarily have to be removed on site. The front of the shoulder pads can be opened to allow access for CPR and defibrillation.

Procedures for Training in Spine Immobilization:

Personnel should review signs and symptoms of spine injury and complete a training session each year with in-line stabilization, rigid cervical collar application, log roll maneuver, and long spine board packaging. Personnel providing football medical coverage should review facemask removal with appropriate tools, helmet removal and shoulder pad removal.

Appendix B

Athletic Training

Sudden Cardiac Arrest Protocol

General Guidelines

1. The initial components of sudden cardiac arrest (SCA) management are early activation of EMS, early CPR, early defibrillation, and rapid transition to advanced cardiac life support (ACLS). Sudden cardiac arrest should be suspected in any collapsed and unresponsive athlete.
2. An AED should be applied as soon as possible on any collapsed and unresponsive athlete for rhythm analysis and defibrillation if indicated.
3. Cardiopulmonary resuscitation should be provided while waiting for an AED.
4. Interruptions in chest compressions should be minimized and CPR stopped only for rhythm analysis and shock.
5. Cardiopulmonary resuscitation should be resumed immediately after the first shock, beginning with chest compressions, with repeat rhythm analysis after every 2 minutes or 5 cycles of CPR, and continued until advanced life support providers take over or the victim starts to move.
6. Sudden cardiac arrest in athletes can be mistaken for other causes of collapse, and rescuers should be trained to recognize SCA in athletes with special focus on potential barriers to recognizing SCA, including inaccurate rescuer assessment of pulse or respirations, occasional or agonal gasping, and myoclonic jerking or seizure-like activity.
7. Young athletes who collapse shortly after being struck in the chest by a firm projectile or by player contact should be suspected of having SCA from commotio-cordis.
8. Rapid access to the SCA victim should be facilitated for EMS personnel.

Appendix C

Athletic Training

Concussion Protocol

General Guidelines

1. Concussions are considered to be mild traumatic brain injuries. There is no discrepancy between mild, moderate, or severe concussions, as all need to be treated equally. Loss of consciousness does not have to occur for a concussion.
2. Removal from play is required by law if there is any indication or suspicion that an athlete has received a concussion, as stated in RCW 28A.600.190 (Lystedt Law).
3. An athlete suspected of having a concussion should receive a sideline concussion assessment utilizing an evidenced based tool.
4. Athletes will be recommended to see a physician if athlete has prolonged symptoms for more than 10 days. The athlete may not return to play/practice until cleared to do so by ATC.

Procedures for return to play

5. Until the athlete has been cleared to begin a return to play protocol, the athlete will see the ATC daily to monitor symptoms. The ATC will determine, in conjunction with the School Nurse if the athlete will need cognitive rest from school and will inform the appropriate school personnel.
6. Athletes must rest until symptoms subside. The athletic trainer will begin the return to play protocol once the athlete has been cleared by the physician and concurrently has significant reduction in symptoms or is symptom free.
7. Athletes progressing through the return to play policy should be removed off of academic rest progressively in coordinating with the return to play policy
8. Once the athlete has reached the final protocol, they may return to full participation.

Appendix D

Athletic Training

Asthma Protocol

General Guidelines

1. Asthma is a chronic inflammatory disorder that affects the airways.
2. Asthma is a common condition that can commonly be triggered by many allergens. It can become deadly if not treated.
3. Asthma can be difficult to determine from Exercise Induced Bronchospasms or Vocal Cord Dysfunction.
4. Masks and nose breathing help to warm and moisturize inhaled air before it reaches the smaller airways. This may decrease the inflammatory reaction in the airways and thus decrease the frequency and intensity of EIA, this however may not work for all athletes.
5. Asthma rescue inhalers should be EASILY accessed. Not stored in a locker. An assistant coach or the Athletic Trainer should know where the rescue inhaler for an athlete is at all times.

Procedures for Asthma Attacks.

6. For mild attacks, assist the athlete with a rescue inhaler. Utilizing the inhaler up to 3 treatments in 1hr.
7. Allow the athlete to remove themselves from play in order to manage the situation. Monitor them and guide them to purse their lips and slow their breathing to reduce irritation to the bronchioles.
8. Determine with a Peak Flow Meter the percentage at which the athlete is able to reproduce their Peak Expiratory Flow.

    - PEF% > 80% should be monitored and allowed to return to play when the athlete is able to maintain normal breathing patterns.
    - PEF% = 61-80% should be monitored and removed from play.

    - PEF % < 60% should be sent for an evaluation by emergency room.

Appendix E

Athletic Training

Diabetic/Insulin Shock Protocol

General Guidelines

1. Diabetes is an endocrine dysfunction that can affect athletes and their ability to perform.

2. Maintaining consistent blood glucose, lipid, and blood pressure are important measures for those with diabetes mellitus.

3. Diabetic and Insulin shock are different conditions that each requires different treatments.

1. Thorough PPEs should identify risk factors for those with Diabetes and their management for athletics. Proper management, carbohydrate supplementation, and insulin adjustment should be all that is needed.

Procedures for Hypoglycemia (Insulin Shock -Low Blood Sugar/High Insulin).

1. Low blood sugar can easily be treated if the athlete is conscious and aware of the situation.
2. Monitor the athlete's vital signs and provide them carbohydrate supplementation. As blood sugar falls athletes often can become despondent and unwilling to cooperate. Dizziness, seizures, sweating, palpitations, hunger, headaches, decrease in cognitive abilities and changes in behavior are common.
3. Should an athlete have blood sugar lower than 70mg/dL and become unconscious, the EAP should be activated immediately and EMS called.

Procedures for Hyperglycemia (Ketosis – High Blood Sugar/Low Insulin)

1. Unlike hypoglycemia, hyperglycemia can be managed, but also may demonstrate similar symptoms. If someone has high blood sugar, it can result in Ketosis, which can be identified with sugar alcohols in the breath. If someone has Ketosis, that should be referred to the E.R.
2. Heavy and intense exercise above 70% VO_2 max can increase levels of blood sugar into the body, especially those who have poor glycemic regulation.
3. Some Athletes will train in a Hyperglycemic state to avoid Hypoglycemia. Management should include consistent monitoring by the athlete and athletic trainer.

Appendix F

Athletic Training

Heat Illness Protocol

General Guidelines

1. Heat illness is defined as any body temperature that causes physiological disruptions to the CNS
2. Heat illnesses are often common with fall and late spring sports. Although uncommon, it can occur with athletes in winter season sports as a result of dehydration.
3. Certified athletic trainers can identify and distinguish heat illnesses from other injuries that exhibit similar symptoms.
4. Heat illnesses can be prevented with proper hydration, and pre-participation physical exams can help identify those who are at an increased risk based on risk factors.
5. Identification will involve taking a primary and secondary survey. Evidence highly suggests that taking a rectal thermometer is scientifically the best indicator of heat stroke.
6. Environment conditions should be factored into when it is safe for activity. Heat acclimatization should be monitored as well as smog and heat index.

Procedures for heat induced illnesses.

7. Athletes suspected of heat illness should be removed from activity and moved into a cool place, this can be shade or inside. Remove excessive clothing and ask the athlete to drink sips of water.
8. Monitor athlete's vital signs until they have been regulated to normal standards.
9. If the athlete's temperature exceeds 104^{o} the athlete should be submerged in cold water and EAP activated. The athlete should be cooled below 102^{o} before transporting to the hospital. If a cold bath is unavailable, utilize cold showers in the locker room or icepacks on the neck, groin, and axillary regions.

Appendix G

Athletic Training

Environmental Cold

General Guidelines Cold

1. While uncommon in Washington, Hypothermia, Chillblains, and Frostbite can occur in athletes who are unprepared for the weather, or those who are predisposed to cold injuries.
2. Ensure athletes have proper coverage for the conditions. Instruct athletes to cover up with warm clothing and to prepare for the rain.
3. Ensure athletes are still drinking water adequately, cold conditions can cause the thirst mechanism to be diminished.
4. Athletes of color, body composition, females, unconditioned athletes, comorbidities, or those who have had a previous cold injury have an increased risk of cold injuries.
5. If an athlete is suspected of having a cold injury such as, they should be removed from the environment as quickly as possible.

General Treatment of Cold Injuries

6. Frostbite: Rewarming of the tissue is best done by water immersion that is no warmer than 98° to 104° F
7. Chillblain: Rewarming of the tissue is best done by dry heat. Do not disrupt blisters or apply friction massages
8. Hypothermia: Rewarming of the tissue is best done by warming the trunk and areas of heat exchange, such as the axillary or groin. Do not apply friction massage as it will increase damage caused by frostbite.

Appendix H

Athletic Training
Lightning Policy

General Guidelines for Lightning

1. Lightning strikes are the second largest environmental cause of death in athletics.
2. All activities must be stopped until 30 minutes after the last thunder is heard within 5 nautical miles (nmi). If there is another lightning strike within 5nmi in that 30 minute period, activity must be halted again and the timer restarted.
3. Counting the distance; seconds between lightning strike and thunder divided by 6 equals nmi away. **Must equal 5nmi in order to return to activities**.
4. If no safe structure is within a reasonable distance, then other safe areas include: enclosed buildings, fully enclosed metal vehicles with windows up (no convertibles or golf carts Unsafe shelter areas: water, open fields, dugouts, golf carts, metal objects (bleachers, fences, etc.), individual tall trees, light poles. AVOID BEING THE HIGHEST OBJECT IN AN OPEN FIELD. ***Athletes/coaches etc. should not stand in groups or near a single tree. There should be 15 ft between athletes (NLSI, 2000).
5. **Note:** sports with metal equipment. Golfers drop your clubs and remove shoes, baseball/softball drop bats and remove shoes, tennis drop rackets.

6. If unable to reach safe shelter, assume a crouched position on the ground with only the balls of the feet touching the ground, wrap your arms around your knees and lower your head. Minimize contact with the ground, because lightning current often enters the victim through the ground rather than by a direct overhead strike. Do not lie flat! If safe shelter is only a short distance away, it's been suggested to run for shelter, rather than stay in middle of field.

7. If a person feels that his/her hair standing on end, they should immediately crouch as described previously. If someone is struck by lightning, activate the Emergency Action Plan. **A person struck by lightning does not carry an electrical charge**; immediately initiate the EAP and begin the primary survey. If possible move victim to a safe location.

    1. Avoid using the telephone except in emergency situations. People have been struck by lightning while using a land-line phone. A cellular phone or a portable phone is a safe alternative to land-line phones, if the person and the antenna are located within a safe structure, and if all other precautions are followed.

Appendix I

Appendix I

Athletic Training
Psychosocial Intervention

Considerations for Psychosocial Intervention

1. Increasing amount of research indicates that while participation in athletics is beneficial to adolescents, there is an increasing amount of data identifying athletics as a risk factor for several psychosocial disorders

2. Many students who perceive themselves as "athletes" often tying it to their identity, Risks to their identity as an athlete such as an injury, poor performance, or team conflicts can result in increased psychological stress.

3. Athletes are at a higher risk for developing abuse patterns with pain medications, mood disorders, eating disorders, and are more likely to experiment with illegal drugs or performance enhancement drugs.

4. It is prudent to discuss appropriate behaviors with athletes as a team, and to develop an environment of inclusion amongst all athletes. Parent education and support are paramount in helping reduce instances of psychosocial disorders.

5. It is important to not state that an athlete has any specific disorder or dysfunction for a couple reasons. One, it can cause the athlete to believe that they are dysfunctional, thus contributing to a compromise of their psychological well being. Secondly, only licensed psychologists are allowed to evaluate and diagnose psychosocial disorders.

6. The district ATCs should be in contact with the school counselor at least once a year to discuss protocols for referral.

Guidelines for Psychosocial Intervention

1. If there is reasonable suspicion that an athlete is having a psychosocial disorder attention needs to be brought to the AD first.

2. The AD will discuss with the school counselor on possible interventions. At this point the School Counselor will intervene if necessary as per school district policy.

3. Guidelines for intervention of illegal substances will follow School Athletic Handbook.

Emergency Equipment Severna Park High School

All necessary emergency equipment should be at or near the site and quickly accessible. Medical personnel and coaches should be familiar with the function and operation of each type of emergency equipment. Equipment should be in good operating condition, and coaching personnel must be trained in advance to use it properly. Emergency equipment should be checked on a regular basis and its use rehearsed by personnel annually. The emergency equipment available should be *appropriate for the level of training* for the first responders. It is important to know the proper way to care for and store the equipment as well. Equipment should be stored in an area for easy access.

AED: an AED with be with the athletic trainer at all practices and games. For fall and spring sports the AED will be in the bed of the GATOR. For winter sports it will be on the sideline with ATC. There is one fixed on the wall in the field house athletic training room. Inside the school building there is an AED fixed on the wall at the entrance of the athletics hallway, to the right of the concession stand when facing it.

Splints: will be with athletic trainer during events and in the Athletic Training rooms during practices.

Appendix J: COVID-19 Considerations

COVID-19

Health department officials note that it is difficult to make blanket statements and policies regarding quarantines. There are nuances to every scenario. When a case is reported the health department will provide further guidance.

1. All coaches, student-athletes, and parents/guardians are expected to continually self-monitor for signs/symptoms of COVID-19 prior to a workout. Signs/symptoms of COVID-19 to be aware of include:

- Fever (over 101.4)
- Cough
- Shortness of breath or difficulty breathing
- Shaking chills

- Chest pain, pressure, or tightness with exercise
- Fatigue or difficulty with exercise
- Racing heart rate
- Unusual dizziness
- Loss of taste or smell

- Sore throat
- Nausea, vomiting, or diarrhea
- Unusual rash or painful discoloration of fingers or toes

1. When a student-athlete or coach is diagnosed with and/or receives a positive notice of COVID-19 the school system and the Anne Arundel County Health Department will be notified immediately.

2. The Anne Arundel County Health Department is responsible for conducting contact tracing in the county and in coordination with the Maryland Department of Health and the school system. When someone tests positive for COVID-19, they will be contacted by a public health worker to get more information about where they have been and who they have been with. A public health worker will contact these exposed individuals (contacts) of their potential exposure as rapidly and sensitively as possible.

3. Schools must be prepared to provide contact tracing information from an AACPS approved attendance form/procedure.

4. Upon screening, any student-athlete or coach with COVID-19 symptoms (as outlined above in the Health and Safety section) shall not be allowed to take part in workouts and should be immediately sent home, and parents contacted. Prior to returning to an in-person session, a physician's diagnosis (viral infection is not acceptable) and/or negative COVID-19 test result documentation must be submitted by the parent/guardian to the athletic department.

5. Immediately upon learning that a student-athlete or coach tests positive for COVID-19, that group/team's in-person activities will cease for 14 days. Everyone involved with the team will be asked to quarantine at home for 14 days from the date of the positive test, monitor for symptoms, and let their health care provider know if symptoms develop. The staff at the school will work with the athletics office to follow the established AACPS communication procedures, as outlined at this website: https://www.aacps.org/coronavirus.

- This plan is not based specifically on the level of direct contact with the positive person, but instead, out of an abundance of caution, is based on everyone with whom that person had any contact in the group setting. At the conclusion of the 14-day quarantine period the group may resume in-person activities with all those who show no symptoms of COVID-19.

1. **Face coverings – coaches/staff.** AACPS coaches and staff will always wear a mask/face covering while interacting with student-athletes.

2. **Face coverings – student-athletes.** Student-athletes will wear a mask/face covering when they are not engaged in physical exertion. Examples include but are not limited to when they are entering and exiting the facility, when they are on the sideline, when they use the bathroom, and when they are receiving treatment from a trainer.

3. **Distancing.** Whenever possible, everyone in a group/pod should maintain at least six feet of distance from all sides when not actively exercising.

4. **Bad Weather Scenarios.** In the event of dangerous weather scenarios that occur after a session starts (ex: lightning strikes), staff and student-athletes who can't leave campus immediately will move indoors to the largest indoor space that is located close to or has its own exterior entrance/exit point (typically a gymnasium/cafeteria/auditorium) while maintaining social distance and wearing masks until their rides arrive. ADs will ensure there is a plan in place to guarantee access to these spaces is always available while students are on campus. Additionally, in order to help reduce the likelihood of having to house large numbers of staff and students indoors, the county and or individual schools may proactively cancel practice sessions based on weather forecasts.

Additional information

6. In cases of student-athletes who have had a previous COVID-19 related illness, the NFHS-AMSSM task force suggests the following:

- Student-athletes with a prior confirmed COVID-19 diagnosis should undergo an evaluation by their medical provider. Written medical clearance is required prior to participation.
- Student-athletes who had mild COVID-19 symptoms that were managed at home should be seen by their medical provider for any persisting symptoms. An electrocardiogram (ECG) may be considered prior to sports participation.
- Student-athletes who were hospitalized with severe illness from COVID-19 have a higher risk for heart or lung complications. A comprehensive cardiac evaluation is recommended in consultation with a cardiology specialist.

- Student-athletes with ongoing symptoms from diagnosed COVID-19 illness require a comprehensive evaluation to exclude heart and lung disorders that carry a risk of arrhythmia, respiratory compromise, sudden cardiac arrest (SCA) or sudden death. These individuals should not return to sports until medically cleared by a physician.
- In addition, student-athletes should be evaluated by their medical provider if they have knowingly had close contact with family members with confirmed COVID-19 cases, if they have underlying medical conditions that place them at a higher risk of COVID-19 or if they had previous symptoms suggestive of COVID-19.

STADIUM/Turf 2

Emergency Personnel: Administration, ATC, Coaches, or Bystanders. **Individuals with lower credentials should yield to those with more appropriate training.**

Emergency Communication: 911

Emergency Equipment: AED fixed in field house athletic training room or with ATC

Roles of First Responders

1. Immediate care of the injured or ill student-athlete

2. Activation of the emergency medical system (EMS). Provide:

    1. *name*, *location*, *telephone* number of caller
    2. nature of emergency, whether medical or non-medical
    3. number of athletes
    4. condition of athlete(s)
    5. first aid treatment initiated by first responder
    6. specific directions as needed to locate the emergency scene
    7. other information as requested by dispatcher

3. Emergency equipment retrieval

4. Direction of EMS to scene

    8. Designate individual to guide EMS to the courts.
    9. Scene control: limit scene to first aid providers and move bystanders away from area

Venue Directions:

Follow Rt. 2 South until Robinson Rd.

Turn right onto Robinson Rd.

Turn right into the first entrance to the school (Bus lanes)

Stadium and turf 2 is on the right of the parking lot, with grass fields continuing along the road

Personnel will be located at each field entrance to direct ambulance

GYMNASIUM/ Wrestling

Emergency Personnel: Administration, ATC, Coaches, or Bystanders. **Individuals with lower credentials should yield to those with more appropriate training.**

Emergency Communication: 911 (9-911 from school line)

Emergency Equipment: AED with ATC, or fixed on wall to the right of the concession stand in gym lobby

Roles of First Responders

1. Immediate care of the injured or ill student-athlete

2. Activation of the emergency medical system (EMS). Provide:

    1. *name, location, telephone* number of caller
    2. nature of emergency, whether medical or non-medical
    3. number of athletes
    4. condition of athlete(s)
    5. first aid treatment initiated by first responder
    6. specific directions as needed to locate the emergency scene
    7. other information as requested by dispatcher

3. Emergency equipment retrieval

4. Direction of EMS to scene

- Designate individual to guide EMS to the courts.
- Scene control: limit scene to first aid providers and move bystanders away from area

Venue Directions:

Follow Rt. 2 South until Robinson Rd.

Turn right onto Robinson Rd.

Enter the parking lot for faculty and staff. This will be the 3rd right into campus if coming from route

Follow the parking lot and enter the Main Gym entrance.

The Gym will be on your left upon entry.

Wrestling/Aux Gym/Weight room

Continue through main gym to doors on the opposite wall from the lobby

Take a left, and follow the hallway to aux gym

The weight room will be left down that hallway

School personnel will be outside to meet EMS

BASEBALL/SOFTBALL FIELD

Emergency Personnel: Administration, ATC, Coaches, or Bystanders. **Individuals with lower credentials should yield to those with more appropriate training.**

Emergency Communication: 911

Emergency Equipment: AED fixed in field house athletic training room or with ATC

Roles of First Responders

1. Immediate care of the injured or ill student-athlete

2. Activation of the emergency medical system (EMS). Provide:

    1. *name, location, telephone* number of caller
    2. nature of emergency, whether medical or non-medical
    3. number of athletes
    4. condition of athlete(s)
    5. first aid treatment initiated by first responder
    6. specific directions as needed to locate the emergency scene
    7. other information as requested by dispatcher

3. Emergency equipment retrieval

4. Direction of EMS to scene

- Designate individual to guide EMS to the courts.
- Scene control: limit scene to first aid providers and move bystanders away from area

Venue Directions:

Follow Rt. 2 South until Robinson Rd.

Turn right onto Robinson Rd.

Turn right into the first entrance to the school (Bus lanes)

Take the access road between stadium and turf 2, someone will unlock the gate

Follow the road to the end and turn left, fields will be on the right

Personnel will be located at each field entrance to direct ambulance

TENNIS COURTS

Emergency Personnel: Administration, ATC, Coaches, or Bystanders. **Individuals with lower credentials should yield to those with more appropriate training.**

Emergency Communication: 911

Emergency Equipment: AED fixed in field house athletic training room or with ATC

Roles of First Responders

1. Immediate care of the injured or ill student-athlete

2. Activation of the emergency medical system (EMS). Provide:

    8. *name, location, telephone* number of caller
    9. nature of emergency, whether medical or non-medical
    10. number of athletes
    11. condition of athlete(s)
    12. first aid treatment initiated by first responder
    13. specific directions as needed to locate the emergency scene
    14. other information as requested by dispatcher

3. Emergency equipment retrieval

4. Direction of EMS to scene

- Designate individual to guide EMS to the courts.
- Scene control: limit scene to first aid providers and move bystanders away from area

Venue Directions:

Follow Rt. 2 South until Robinson Rd.

Turn right onto Robinson Rd.

Turn right into the first entrance to the school (Bus lanes)

Tennis courts is on the right behind the home stands of stadium

Personnel will be located at each field entrance to direct ambulance

Kinder Park/Middle School- Cross Country or Track Practices

Emergency Personnel: Coaches, or Bystanders. **Individuals with lower credentials should yield to those with more appropriate training.**

Emergency Communication: 911

Emergency Equipment:

There is an AED with athletic trainer

Roles of First Responders

1. Immediate care of the injured or ill student-athlete

2. Activation of the emergency medical system (EMS). Provide:

15. *name, location, telephone* number of caller
16. nature of emergency, whether medical or non-medical
17. number of athletes
18. condition of athlete(s)
19. first aid treatment initiated by first responder
20. specific directions as needed to locate the emergency scene
21. other information as requested by dispatcher

3. Emergency equipment retrieval

4. Direction of EMS to scene

- Designate individual to guide EMS to the courts.
- Scene control: limit scene to first aid providers and move bystanders away from area

Venue Directions:

Going North on Jumpers Hole Rd.

Make a left at 450 Jumpers Hole Rd.

Team meets on the left hand side of the school building

Personnel will be located at each field entrance to direct ambulance