

## Chapter 3 – Manager/Coach Safety

March, 2018

To All Managers and Coaches:

Welcome to another fun and exciting season of **East Point Seffner Little League** Baseball!

As recommended by Little League Baseball®, Inc., the Board of Directors is once again distributing the 2018 East Point Seffner Little League ASAP Plan in an effort to help our Managers, Coaches, parents and volunteers comply with our safety standards. In conjunction with the Florida - District 13 Safety Officer, we have included a comprehensive look at how our League should promote safety standards.

These safety procedures will be distributed to all Managers/Coaches, parents, and volunteers as follows:

- Managers/Coaches can download a copy of **Chapter 3 - Manager/Coach** of the Safety Manual (after approval as a Manager/Coach) from the EPLL League website.
- Managers will discuss the **Chapter 4 - Parent Safety** of the Safety Manual with the parents at their first team/parent meeting/practice. This chapter will also be available on the League website for parents to download.
- Managers will go over the **East Point Seffner Little League Safety Code** with all players on their team at the first team/parent meeting.
- All Concession Stand volunteers will receive a copy **Chapter 5 - Concession Safety** of the Safety Manual to read *before* they can perform concession duty.

As the spring season progresses, we ask that everyone check and see if there are other safety procedures that can be implemented.

The commitment to this 2018 East Point Seffner Little League ASAP Plan is proof that we at **East Point Seffner Little League** are dedicated to this cause. Please read this material carefully, as it will familiarize you with safety fundamentals. Keep the manual with you at all times as a reference guide to be safe and prepared throughout the season.

In closing, remember that safety rests with all of us, the volunteers of **East Point Seffner Little League**. Always use common sense, never doubt what children tell you, and report all accidents or safety infractions when they occur. *Play ball and play it safe!*

Best wishes for a safe Little League season,

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Nathan Swan, League President

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Terry Childers, League Safety Officer

## Safety Manual and First Aid Kits

Each Manager will be issued a First Aid Kit at the beginning of the season. The Manager for the team will go over this safety information with all his/her coaches.

Managers/Coaches can check the *Manager/Coach Safety* section of the ASAP plan to find phone numbers to the local hospital, other emergency services, the Board of Director contact info, the **East Point Seffner Little League Code of Conduct**, and basic information on First Aid, CPR, and player safety.

Each team's First Aid Kit will include the necessary items to treat an injured player until professional help arrives.

The First Aid Kit must be with the Manager at all practices, batting cage practices, games (season games and post-season games) and any other event where team members could become injured or hurt.

## Important Phone Numbers

Terry Childers, League Safety Officer..... **(813) 368-7799**

Williamsport Insurance Claim Office..... **(570) 326-1921**

Brandon Regional Hospital..... **(813) 681-5551**

Hillsborough County Sheriff – Emergency... **9-1-1**

Fire Safety – Emergency..... **9-1-1**

## Board of Director Information

Board Member	Phone	E-mail
<b>Nathan Swan</b> President	(863) 738-0654	cnrr@ymail.com
<b>OPEN</b> Vice President		
<b>Lauren Hughes</b> Treasurer	(813) 523-2942	Lhughes0915@gmail.com
<b>Michelle Barry</b> Secretary	(813) 727-4048	mbarry@tampabay.rr.com
<b>Michelle Barry</b> Player Agent	(813) 727-4048	mbarry@tampabay.rr.com
<b>Terry Childers</b> Safety Officer	(813) 368-7799	Lyndatlc2@yahoo.com
<b>Lynda Childers</b> Concession Director	(813) 270-4212	Lyndatlc2@yahoo.com
<b>Chris Childers</b> Coaching Coordinator	(813) 360-3174	
<b>Kim Hansen</b> Sponsors/Fundraising	(813) 239-6168	Smilekimmy31@gmail.com

## Manager/Coach Code of Conduct

The Board of Directors of **East Point Seffner Little League** has mandated the following ***Manager/ Coach Code of Conduct***. All Managers/Coaches will read and comply with this *Code of Conduct*.

### Managers and Coaches shall not:

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| <ul style="list-style-type: none"><li>• At any time lay a hand upon, push, shove, strike, or threaten to strike an Umpire.</li><li>• Use verbal or physical abuse upon any Umpire for any real or imaginary belief of a wrong decision or judgment.</li><li>• Show objectionable demonstration of dissent at an Umpire's decision by throwing of gloves, helmets, hats, bats, balls, or any other unsportsmanlike-like action.</li><li>• Allow players to use unnecessarily rough tactics in game play against the body of an opposing player.</li><li>• Physically attack any Board Member, official Manager, Coach, player or spectator.</li><li>• Use of profane, obscene or vulgar language in any manner at any time.</li><li>• Appear anywhere on the EPLL League complex while in an intoxicated state at any time.</li></ul> | <ul style="list-style-type: none"><li>• Gamble upon any play or outcome of any game with anyone at any time.</li><li>• Smoke while in the stands or on the playing field or in any dugout at any time.</li><li>• Discuss publicly with spectators in a derogatory or abusive manner any play, decision or a personal opinion on any players during the game.</li><li>• Mingle with or fraternize with spectators during the course of the game.</li><li>• Speak disrespectfully to any Manager, Coach, Umpire or representative of the league.</li><li>• Tamper or manipulate of any league rosters, schedules, draft positions or selections, official score books, rankings, financial records or procedures.</li><li>• Challenge an Umpire's authority. The Umpires shall have the authority and discretion during a game to penalize the offender according to the infraction up to and including removal from the game.</li></ul> |
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The Board of Directors will review all infractions of the ***Manager/Coach Code of Conduct*** and may assess additional disciplinary action.

## East Point Seffner Little League Safety Code

The Board of Directors has mandated the following **East Point Seffner Little League Safety Code**. Managers/ Coaches must read this **League Safety Code** to their players, ensuring they all understand and agree to comply with the **League Safety Code**.

- Responsibility for safety procedures belong to every adult member of East Point Seffner Little League.
- Each Player, Manager, designated Coach, and Umpire, shall use proper reasoning and care to prevent injury to himself and others.
- Only League-approved Managers and/or Coaches are allowed to practice teams and supervise batting cages.
- Managers and designated Coaches will take the mandatory Hillsborough County Volunteer/Concussion/CPR training.
- First-aid kits are issued to each team Manager during the pre-season and must be brought to all games and practices.
- No games or practices will be held when weather or field conditions are poor, especially when lighting is inadequate or there is lightning in the area.
- A lightning detection meter will be kept in the Concession Stand at all times for inclement weather.
- Playing fields will be inspected before games and practices for holes, damage, stones, glass and other foreign objects.
- Team equipment should be stored within the team dugout or behind screens, and not within the area defined by the Umpires as "in play."
- Only Players, Managers, Coaches and Umpires are permitted on the playing field or in the dugout during games and practice sessions.
- Responsibility for keeping bats and loose equipment off the field of play should be that of a player assigned for this purpose or the team's Manager and designated Coaches.
- Foul balls batted out of playing area will be returned to the appropriate individual and not thrown over the fence during a game.
- During practice and games, all players should be alert and watching the batter on each pitch.
- During warm-up drills, players should be spaced so that no one is endangered by wild throws or missed catches.
- All pre-game warm-ups (i.e., playing catch, pepper, swinging bats, etc.) should be performed within the confines of the playing field and not within areas that are frequented by spectators.
- Equipment should be inspected regularly for condition as well as for proper fit.
- Batters must wear Little League-approved protective helmets that bear the NOCSAE seal during batting practice and games.
- Head-first slides are not permitted, except when a runner is returning to a base.
- Disengageable bases will be used on ALL fields.
- At no time should "horse play" be permitted on the playing field.

- Parents of players who wear glasses should be encouraged to provide "safety glasses" for their children.
- On-deck batters are not permitted.
- Managers will only use approved Little League baseballs.
- All male players will wear athletic supporters or cups during games.
- Male catchers must wear the metal, fiber or plastic-type cup and a short- or long-model chest protector with neck collar, throat guard, shin guards and catcher's helmet, all of which must meet Little League specifications and standards.
- Female catchers must wear a long or short model chest protector.
- All catchers must wear chest protectors. All catchers must wear a mask, "dangling" type throat protector and catcher's helmet during practice, pitcher warm-up, and games. [**Note:** *Skullcaps are not permitted.*]
- Shoes with metal spikes or cleats are *not* permitted, except in the Junior/Senior Baseball division. Shoes with molded cleats are permissible.
- Players will not wear watches, rings, pins, jewelry or other metallic items during practices or games. [**Exception:** *Medical Alert jewelry; must be taped in place.*]
- No food or drink, at any time, in the dugouts. [**Exception:** *Coolers with water supplied by the League.*]
- Baseball and softball catchers must wear the appropriate mitt for their division.
- Catchers must wear full catcher's gear as described above, when warming up a pitcher in practices or games.
- Managers will never leave children unattended at a practice or game.
- No children under the age of 15 are permitted in the Concession Stand.
- Never hesitate to report any present or potential safety hazard immediately to the Board Member on Duty.
- No alcohol or drugs allowed on the premises at any time.
- *No medication* will be taken at the facility unless administered directly by the child's parent. This includes aspirin and Tylenol.
- No playing in the parking lots, construction areas or sand bins at any time.
- No playing on and around lawn equipment or machinery at any time.
- No swinging of bats or throwing baseballs at any time within the walkways and common areas of the complex.
- No throwing rocks, climbing fences, or swinging on dugout roofs.
- Players and spectators should be alert at all times for foul balls and errant throws.
- All gates to the fields must remain closed at all times. After players have entered or left the playing field, gates should be closed and secured.
- Riding bicycles, skateboards, and motorized scooters are not permitted on the premises.
- No one is allowed on the complex with open wounds at any time. Wounds should be treated and properly bandaged.
- No running allowed in the bleachers.

## The Manager's Safety Role

The Manager is appointed by the President of the League to be responsible for the team's actions on the field, and to represent the team in communications with the Umpire and the opposing team. The Manager shall always be responsible for the team's conduct, observance of the official rules and deference to the Umpires.



- The Manager is also responsible for the safety of his players. He/she is also ultimately responsible for the actions of designated Coaches.
- If a Manager leaves the field, that Manager shall designate a *Coach* as a substitute and such substitute Manager shall have the duties, rights and responsibilities of the Manager.

### During Pre-Season

- Attend the mandatory Volunteer Training as set-up by the Hillsborough County Athletics Department (see **Section 2** for training schedules).
- Read **Chapter 3 - Manager/Coach Safety** of the 2018 East Point Seffner Little League ASAP Plan and obtain the First-Aid Kit supplied by the league.
- Meet with all parents at the first practice to discuss Little League philosophy and safety issues.
- Cover the basics of *safe play* with his/her team before starting the first practice.
- Read the **Manager/Coach Code of Conduct** and the **East Point Seffner Little League Safety Code** in this manual to all players/parents before the first game.
- Teach players the fundamentals of the game while advocating safety.
- Teach players the correct way to slide before the season starts.
- Notify parents that if a child is injured or ill for an extended period of time, the player cannot return to practice unless they have a note from their doctor. This medical release protects you if that child should become further injured or ill.
- Encourage players to bring water bottles to practices and games.
- Tell parents to bring sunscreen for themselves and their child.
- Encourage players to wear mouth protection.
- Work closely with League Safety Officer and League Equipment Manager to make sure equipment is in first-rate working order.

### During Season Play

- Not expect more from their players than what the players are capable of.
- Teach the *fundamentals* of the game to players:

- Catching fly balls
- Sliding correctly
- Proper fielding of ground balls
- Simple pitching motion for balance
- Be open to ideas, suggestions or help.
- Enforce that *prevention* is the key to keeping accidents to a minimum.
- Have players wear sliding pads if they have cuts or scrapes on their legs.
- Always have the First-Aid Kit and Safety Manual on hand.
- Use common safety sense.

### **During Pre-Game and Practice**

- Make sure that players are healthy, rested and alert.
- Make sure that players returning from being injured have a medical release form signed by their doctor; otherwise, they can't play.
- Make sure players are wearing the proper uniform and catchers are wearing a cup.
- Make sure that the equipment is in good working order and is safe.
- Check the field area for safety hazards using the *Field and Games Safety Checklist* (see **Appendix**).
- Enforce the rule that no bats and balls are permitted on the field until all players have done their proper stretching. (See **Conditioning and Stretching**.)
- Have players do a light jog around the field before starting throwing warm-ups that should follow this order:
  - Light tosses - short distance
  - Light tosses - medium distance
  - Light tosses - large distance
  - Medium tosses - medium distance
  - Regular tosses - medium distance
  - Field ground balls
- Field pop flies.

### **During the Game**

- Make sure that players carry all gloves and other equipment off the field and to the dugout when their team is up at bat. No equipment shall be left lying on the field, either in fair or foul territory.
- Keep players alert.
- Maintain discipline at all times.



- Be organized.
- Keep players and substitutes sitting on the team's bench or in the dugout unless participating in the game or preparing to enter the game.
- Make sure catchers are wearing the proper equipment.
- Encourage everyone to think *Safety First*.
- Observe the **no on-deck** rule for batters and keep players behind the screens at all times. No player should handle a bat in the dugouts at any time.
- Turn personal cell phones off during the game.
- Get players to drink fluids often so they do not dehydrate.
- Not play children that are ill or injured.
- Attend to children that become injured in a game.
- Not lose focus by engaging in conversation with parents and spectators.

### **Post Game**

- Do cool-down exercises with the players.
  - Light jog.
  - Stretching as noted in this manual.
  - Pitchers and catchers who throw regularly should ice their shoulders and elbows.
  - Catchers should ice their knees.
- Not leave the field/complex until every team member has been picked up by a known family member or designated driver.
- Notify parents if their child has been injured no matter how small or insignificant the injury is. *There are no exceptions to this rule.* This protects you, Little League Baseball, Incorporated® and the League.
- Discuss any safety problems that occurred before, during or after the game with the League Safety Officer.
- Fill out an accident report for any injuries and give to **Terry Childers**, League Safety Officer.
- Return the field to its pre-game condition, per League policy.

If a Manager knowingly disregards safety, he or she will come before the Board of Directors to explain his or her conduct.

## **Equipment**

The League Equipment Manager is responsible for purchasing and distributing equipment to the individual teams. This equipment is checked and tested when it is issued, but it is the Manager's responsibility to maintain the equipment in good order. Managers should inspect equipment before each game and each practice.

**The Equipment Manager will promptly replace damaged and ill-fitting equipment.**

Many players like to use their own gear. This equipment can only be used if it meets the requirements as outlined in this ASAP plan and the Official Little League® Rule Book.

At the end of the season, all equipment and First-Aid kits must be returned to the Equipment Director.

## Attitude

Unsafe acts are far more difficult to control than hazardous conditions. They are challenging to Managers and Coaches because they involve the human element. It has been estimated that unsafe acts account for 80% of all accidents. Take definite steps to counteract them:

An attitude of alertness, hustle and enthusiasm is recommended as a guideline for good Coaching, and should be carried down to all players to spark them in the development of better skills.

Good sportsmanship and courtesy, which are both necessary for a harmonious and safe environment, can be best taught through the good example set by all adults—on and off the field.

A Manager's most effective tool is to have an attitude of self-confidence in front of his/her players and to use *praise* and *recognition* towards his/her players. Praise must be given when deserved so it is not cheapened by too much repetition. A player rewarded by a word of encouragement after a good try may make for a good play on the next attempt.

Guidance on the most constructive attitude or point-of-view for both adults and youngsters can be summarized by recommending a *positive* approach to all training techniques. Good training is the most effective weapon against accidents caused by unsafe acts.

## Warm-Up Drills

Use of the term "warm-up drills" in connection with safety refers to ball handling practice rather than calisthenics. Misdirected balls can result in serious accident exposure. The following practices will help reduce the danger of being struck by a misdirected ball:

- All unauthorized people must remain off the field during drills.
- After the number of targets has been reduced to a minimum, one of the best preventive measures is to stress that *the eye must be kept on the ball*. This safe practice should be drilled so continuously that it becomes a reflex action.
- Throwing and catching drills should be set-up with players in two lines facing one another.

## Safe Ball Handling



Misjudging the flight of a batted ball may be corrected by drilling with fly balls which begin easy, and are made more difficult as a player's judgment and

skills improves. Everyone should eventually be able to handle balls that go overhead.

In addition to a player never losing sight of a ball from the time it leaves the bat, the player should keep the glove positioned and the body relaxed for a last split-second move, if needed.

An infielder can best be protected by an aggressive short-hop fielding play by always keeping the "nose pointed at the ball" and the eyes glued on it. In addition, by moving forward, the player is in a better position to make a throw.

It is safer for a player to knock a ball down and re-handle it than to let the ball determine the play.

## **Collisions**

Collisions result in more injuries than is the case with most other types of accidents. They are usually caused by errors in judgment or lack of teamwork between fielders. It is important to establish zones of defense to avoid collisions.

It is particularly important when players are chasing high fly balls. Once the zones are established, play situation drills should be held until these moves and patterns become familiar to the players. The responsible player should call out his/her intentions in a loud voice to warn others away.

Some general rules to follow:

- The fielder at third base should catch all balls that are reachable and are hit between third and the catcher.
- The fielder at first base should catch all balls that are reachable and are hit between first base and the catcher.
- The shortstop should call all balls reachable that are hit behind third base.
- The fielder at second base should call all balls reachable that are hit behind first base.
- The shortstop has the responsibility for fly balls hit in the center of the diamond and in the area of second base. Since the glove is on the left hand, it is easier for the shortstop than the fielder at second to catch fly balls over second base.
- The center fielder has the right-of-way in the outfield and should catch all balls that are reachable. Another player should take the ball if it is seen to be unreachable by the center fielder.
- Outfielders should have priority over infielders for fly balls hit between them.

Priorities are not so easy to establish on ground balls, but most Managers expect their third base player to field all ground balls they can reach, including cutting in front of the shortstop on slow-hit grounders.

The catcher is expected to field all topped and bunted balls that can be reached, except when there is a force play or a squeeze play at home plate.

## Sliding Safety

As is the case with other baseball fundamentals, a correct slide is also a safe one. It is well to guard against the accident of a collision and the possibility of a player being struck by a thrown ball as the player "hits the dirt."

- Long grass has been shown to be better than sand or a sawdust pit for teaching sliding.
- Disengageable bases are required by Little League on ALL fields to prevent injury.
- Sliding pads are recommended.



The player should keep in mind that on approach, hands and feet should be in the air. Once committed to slide, the player must not change strategy. Last minute hesitation causes most sliding injuries.

Tennis shoes are suggested for beginning sliding and tagging practice to avoid injury to the defensive player.

If the ground along the baselines becomes soft on a rainy day, such weather offers an excellent opportunity to have sliding drills. Base runners should wear long pants.

Head-first sliding has been eliminated for ages 12 and under, except when returning to a base.

## Batter Safety



A batter's greatest accident exposure is from the unsafe acts of others, namely wild pitches, which account for a major portion of all accidents. The best defense is an alert, confident concentration on the ball. This type of injury is more prevalent in Major rather than in Minor League play.

Because the danger increases as pitchers learn to throw with greater force, and as more games are played, it is doubly important to take whatever counter-measures are necessary.

A well-fitted NOCSAE-approved helmet is the first requirement.

The development of the novice batter's ability to take evasive action can be improved by getting the player to relax and concentrate on the ball from the time the pitcher starts his/her delivery until it lands in the catcher's mitt. Players with slow reflexes can also be helped by simulated batting and ducking practice with a tennis ball.

The unsportsmanlike practice of crowding the plate or jumping around to rally the pitcher should not be allowed. This could endanger the batter if it causes the pitcher to lose control.

Painful finger and hand injuries can be reduced by making sure the batter holds the bat correctly when bunting. Youngsters have a tendency to lean too far over the plate and not keep the ball well out toward the end of the bat.

When the batter becomes a base runner, the player should be taught to run outside the foul lines when going from home plate to first base and from third base to home plate to reduce the risk of being hit by a thrown ball.

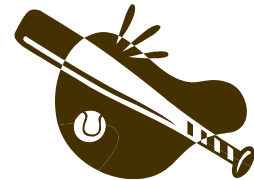
## Safe Handling of Bats

The most easily prevented type of accident is the too frequent fault of beginners throwing the bat while running to first base. This unthinking act may be corrected through individual instruction to drop the bat safely by:

- Having the player drop the bat in a marked-off circle near where running starts;
- Counting the player "out" in practice whenever the player fails to drop the bat correctly;
- Providing bats with grips that are not slippery.

Managers, Coaches and Umpires should be on the alert to correct batters who have a tendency to step into the catcher as they swing.

A more serious injury that might occur is when a player inadvertently walks into the swing of a coach's bat when the Coach is hitting fly balls or walking into the swing of a player swinging a bat.



These situations demonstrate the need for everyone to become safety-minded, for their own good and the safety of others. The following precautions are suggested:

- Assign a player, usually a catcher, to catch balls for the Coach hitting fly balls. The catcher should also be given the specific assignment of warning away anyone who comes too close.
- All players and adults should be trained to walk around batters swinging a bat. The ingrained safety habit of keeping clear may save someone a painful injury.

## Catcher Safety

The catcher, as might be expected from the amount of action involved, has more accidents than any other player. Statistics show that the severity of injuries is less in Major League play than in Minor League play. This bears out the fact that the more proficient the player, the less chance of injury.

Assuming the catcher is wearing the required protection, the greatest exposure is to the ungloved hand. The catcher must learn to *relax*:



- Always have the back of the throwing hand toward the pitcher when in position to catch;
- Hold all fingers in a cupped position near the mitt, ready to trap the ball and throw it when runners are on base.

The catcher should be taught to throw the mask and catcher's helmet in the direction opposite the approach in going for a high fly. The catcher should hold the mask and flip it away at the last moment

As the catcher learns to play this difficult position, a good habit is to keep a safe distance back from the swinging bat. Estimate this distance as one foot farther from the batter than the ends of the outstretched fingers.

The best protection is keeping the eye on the ball.

## General Inattention

Going back to the "why" of most ball handling accidents, it appears that inattention due to inactivity or boredom is an underlying accident cause that Managers must deal with. This situation can be partly offset by using idle time to practice the basics of skillful and safe play, such as:

- Encourage otherwise idle fielders to "talk it up." Plenty of chatter encourages hustle and enthusiasm.
- Players waiting for a game or practice to start can pair-off and play catch to improve their basic eye-on-the-ball technique.
- Practice should include plenty of variety in the drill work.
- Put a time limit on each drill and do not hold the total practice for more than two hours or less, if interest begins to lag.

Idle players along the sideline can be given the job of studying the form of other players to improve their own techniques. They may then report on what they have learned to improve their own form on running, ball handling, throwing, batting, defense and sliding.

## Controlling Horseplay

Horseplay includes any type of youthful, distracting behavior that could even remotely be the cause of an accident.

Team play requires 100% cooperation among players. If showoffs and smart-alecks cannot find sufficient outlet for their high spirits in a game, then quick and impartial disciplinary action must be taken.



## Conditioning and Stretching

Conditioning is an intricate part of *accident prevention*. Extensive studies on the effect of conditioning, commonly known as *warm-up*, have demonstrated that:

- The *stretching* and *contracting* of muscles just before an athletic activity improves general control of movements, coordination and alertness.
- Such drills also help develop the *strength* and *stamina* needed by the average youngster to compete with minimum accident exposure.

The purpose of stretching is to increase *flexibility* within the various muscle groups and prevent tearing from *overexertion*. Stretching should never be done forcefully, but rather in a gradual manner to encourage looseness and flexibility.

### **Stretching Tips**

- Stretch necks, backs, arms, thighs, legs and calves.
- Don't ask the child to stretch more that he or she is capable of.
- Hold the stretch for at least 10 seconds.
- Don't allow bouncing while stretching. This tears down the muscle rather than stretching it.
- Have a different player lead the stretching exercises each practice.

### **Calisthenics Tips**

- Repetitions of at least 10.
- Have kids synchronize their movements.
- Vary upper body with lower body.
- Keep the pace up for a good cardio-vascular workout.

Staying injury-free throughout the sports season requires a proper conditioning and exercise program. On the next two pages are some stretching exercises developed by the American Academy of Orthopedic Surgeons that young athletes can perform before participating in any athletic activity.

Athletes must do each one of the exercises carefully, speed is not important. Once the exercise routine is learned, the entire program should take no longer than 10 minutes.

It also is important to warm up before doing any of these exercises. Good examples of warm up activities are slowly running in place and walking for a few minutes. See the **Appendix** for the *Suggestions for Warm-Up Drills* poster.

## **Florida Weather Safety**

Thankfully, most of our days in Florida are warm and sunny, but there are those days when the weather gets *real* hot or turns bad (especially during hurricane season), creating unsafe weather conditions.

### **Rain**

If it begins to rain:

- Evaluate the strength of the rain. Is it a light drizzle or is it pouring?
- Determine the direction the storm is moving.
- Evaluate the playing field as it becomes more and more saturated.
- Stop practice if the playing conditions become unsafe—use common sense. If playing a game, consult with the other Manager and the Umpire to formulate a decision.



## **Lightning**

The average lightning strike is 5-6 miles long with up to 30 million volts at 100,000 amps flow in less than a tenth of a second.

The average thunderstorm is 6-10 miles wide and moves at a rate of 25 miles per hour.



Once the leading edge of a thunderstorm approaches to within 10 miles, you are at immediate risk due to the possibility of lightning strokes coming from the storm's overhanging anvil cloud. This is why many lightning deaths and injuries occur with clear skies overhead.

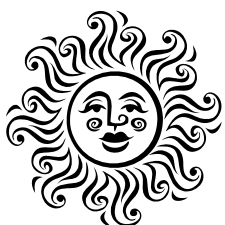
On average, the thunder from a lightning stroke can only be heard over a distance of 3-4 miles, depending on terrain, humidity and background noise around you. By the time you can hear the thunder, the storm has already approached to within 3-4 miles!

The sudden cold wind that many people use to gauge the approach of a thunderstorm is the result of down drafts and usually extends less than 3 miles from the storm's leading edge. By the time you feel the wind, the storm can be less than 3 miles away!

If you can **hear, see** or **feel** a **thunderstorm**:

- Suspend all games and practices immediately.
- Stay away from metal including fencing and bleachers.
- Do not hold metal bats.
- Get players to walk, not run to their parent's or designated driver's cars and wait for your decision on whether or not to continue the game or practice.

## **Ultra-Violet Ray Exposure**



The sun's rays are the strongest from 10:00 a.m. to 4:00 p.m., especially during the late spring and summer. Exposure to ultra-violet rays during a normal Florida day increases and athlete's risk of developing a specific type of skin cancer known as **melanoma**, even if the day is overcast.

The American Academy of Dermatology estimates that children receive 80% of their lifetime sun exposure by the time that they are 18 years old. The League recommends the use of sunscreen with at least 30 SPF as a means of protection from damaging ultra-violet light.

It is equally important to protect your eyes from the sun. The Tampa Bay area is known for having one of the highest rates of cataract surgery in the country. One of the many risks for getting cataracts can be caused by prolonged exposure to ultraviolet light by not wearing sunglasses to protect the eyes.

Although it has not been proved, another risk factor of prolonged exposure to ultraviolet light may be macular degeneration, the leading cause of vision loss in people age 60 and over.





Not all tinted glasses—even very dark ones—protect against UV radiation. The UV filtration results from an invisible chemical applied to the sunglasses. Check the label when choosing sunglasses in order to make sure that they provide protection against UV radiation.

### **Hot Weather and Dehydration**

Florida is well known for hot weather. Precautions must be taken in order to make sure the players on your team do not *dehydrate* or *hyperventilate*. (see also: **Heat Illness**)

Suggest players take drinks of water when coming on and going off the field between innings.



If a player looks distressed while standing in the hot sun, substitute that player and get him/her into the shade of the dugout ASAP.

- If a player should collapse as a result of heat exhaustion, call **9-1-1** immediately. Get the player to drink water and use the instant ice bags supplied in your First-Aid Kit to cool him/her down until the emergency medical team arrives.

## **Pitching and Pitch Count**

### **Why Pitch Count Matters**

Sports doctors continuously lecture to youth baseball Managers and Coaches about pitching injuries and how to prevent them. Remember, in the major leagues, a pitcher is removed after approximately 100 pitches. ***A child cannot be expected to perform like an adult!***

Little League Managers and Coaches are usually quick to teach their pitchers how to get movement on the ball. Unfortunately the technique that older players use is not appropriate for children 13 years and younger. The snapping of the arm used to develop this technique will most probably lead to serious injuries to the child as he/she matures.

Arm stress during the acceleration phase of throwing affects both the inside and the outside of the growing elbow. On the inside, the structures are subjected to distraction forces, causing them to pull apart. On the outside, the forces are compressive in nature with different and potentially more serious consequences.

The key structures on the inside of the elbow include the tendons of the muscles that allow the wrist to flex and the growth plate of the “knobby” bone on the inside of the elbow. The forces generated during throwing can cause this growth plate to pull away from the main bone. If the distance between the growth plate and main bone is great enough, surgery is the only option to fix it. This growth plate does not fully adhere to the main bone until age 15!

Similarly, on the outside (or lateral) aspect of the elbow, the two bony surfaces can be damaged by compressive forces during throwing. This scenario can lead to a condition called *Avascular Necrosis* or *Bone Cell Death* as a result of compromise of the local blood flow to that area. This disorder is permanent and often leads to fragments of the bone breaking away (loose bodies)

which float in the joint and can cause early arthritis. This loss of elbow motion and function often precludes further participation.

- Studies have demonstrated that curveballs cause most problems at the inside of the elbow due to the sudden contractive forces of the wrist musculature.
- Fastballs, on the other hand, place more force at the outside of the elbow.
- Sidearm delivery, in one study, led to elbow injuries in 74% of pitchers compared with 27% in pitchers with a vertical delivery style.

Preliminary studies by a sports doctor funded by USA Baseball several years ago demonstrated the following:

- A significantly higher risk of *elbow* injury occurred after pitchers reached 50 pitches/outing.
- A significantly higher risk of *shoulder* injury occurred after pitchers reached 75 pitches/outing.
- In one season, a *total of 450 pitches or more* led to cumulative injury to the elbow and the shoulder.
- The mechanics, *whether good or bad, did not* lead to an increased incidence of arm injuries.
- The preliminary data suggest that throwing curveballs increases risk of injury to the shoulder more so than the elbow; however, more research needed to be undertaken to investigate whether or not the older children were the pitchers throwing the curve.
- The pitchers who limited their pitching repertoire to the fastball and change-up had the lowest rate of injury to their throwing arm.
- A slider increased the risk of *both elbow and shoulder* problems.

Based on this research, Little League recommends not teaching or throwing of curveballs under the age of 13. If a curveball is taught, the Manager should instruct the child to throw the curveball like a football without snapping the arm or the wrist. If the Manager or Coach is unsure how to do this, he/she can consult teaching materials or contact a Coach in the League that is knowledgeable in this area.

Ice is a universal First-Aid treatment for minor sports injuries. Ice controls the pain and swelling. Pitchers should be taught how to ice their arms at the end of a game. If the Manager or Coach is unsure how to do this, he/she can consult teaching materials or contact a Coach in the League that is knowledgeable in this area.

Once the pitch counts are reached, as set forth by the new Pitch Count Rule, the pitcher must be removed. Should that player be inserted back into the lineup, we recommend against the position of catcher as the number of throws required mirrors that of the pitcher.

**Children should not be encouraged to “play through pain.” Pain is a warning sign of injury. Ignoring it can lead to greater injury.**

## **Pitch Count Rules**

The Manager must remove a pitcher (the pitcher may remain the game at another position) when he/she has reached the following limit for his/her age group:

<b>League Age:</b>	7-8 .....	50 pitches per day
	9-10 .....	75 pitches per day
	11-12 .....	85 pitches per day
	13-16 .....	95 pitches per day

### **PITCHING REST REQUIREMENTS – LA 14 AND UNDER**

- 66 or more pitches in a day = four (4) calendar days of rest.
- 51-65 pitches in a day = three (3) calendar days of rest.
- 36-50 pitches in a day = two (2) calendar days of rest.
- 21-35 pitches in a day = one (1) calendar day of rest.
- 1-20 pitches in a day = no (0) calendar day of rest.

### **PITCHING REST REQUIREMENTS – LA 15-16**

- 76 or more pitches in a day = four (4) calendar days of rest.
- 61-75 pitches in a day = three (3) calendar days of rest.
- 46-60 pitches in a day = two (2) calendar days of rest.
- 31-45 pitches in a day = one (1) calendar day of rest.
- 1-30 pitches in a day = no (0) calendar day of rest.

## **Medical and First Aid Treatment**

### **Giving First-Aid**

**First-Aid** means exactly what the term implies—it is the *first care* given to a victim. It is usually performed by the *first person* on the scene and continued until professional medical help arrives (**9-1-1** paramedics). At no time should anyone administering First-Aid *go beyond* his or her capabilities. *Know your limits!*



The average response time on **9-1-1** calls is 5-7 minutes. En-route Paramedics are in constant communication with the local hospital at all times preparing them for whatever emergency action might need to be taken. You cannot do this. Therefore, do not attempt to transport a victim to a hospital. Perform whatever First Aid you can and wait for the paramedics to arrive.

### **First Aid-Kits**

- First Aid Kits will be furnished to each team at the beginning of the season.
- The League Safety Officer's *name and phone number* will be taped on the inside lid of all First-Aid Kits.



- The First Aid Kit will become part of the team's equipment package and shall be taken to all practices, batting cage practices, games (whether season or post-season) and any other League event where children's safety is at risk.
- To replenish materials in the Team First Aid Kit, the Manager, or designated Coaches must contact the League Safety Officer.
- First Aid Kits must be turned in at the end of the season along with your equipment package.
- The First Aid Kit comes in a plastic white box and should include the following items:

Instant Ice Packs	Eye Pads
Plastic Bags for Ice	Burn Cream Packs
Antiseptic Wipes	Scissors
Roll of Gauze	
Large Bandages 2"x4"	Pair of Latex Gloves
Large Non-stick Bandages	Tweezers
Band-Aids 1"x3"	Sterile Gauze Pads
Antiseptic Cream Packs	
Cloth Athletic Tape	

If you are missing any of the above items, contact the League Safety Officer immediately. Additional First-Aid Kits are available from the Safety Officer.

### **Good Samaritan Laws**

There are laws to protect you when you help someone in an emergency situation. The **Good Samaritan Laws** give legal protection to people who provide emergency care to ill or injured persons. When citizens respond to an emergency and act as a *reasonable* and *prudent* person would under the same conditions, Good Samaritan immunity generally prevails. This legal immunity protects you, as a rescuer, from being sued and found financially responsible for the victim's injury. For example, a reasonable and prudent person would:

- Move a victim only if the victim's life was endangered.
- Ask a conscious victim for permission before giving care.
- Check the victim for life-threatening emergencies before providing further care.
- Summon professional help to the scene by calling **9-1-1**.
- Continue to provide care until more highly trained personnel arrive.

Good Samaritan laws were developed to encourage people to help others in *emergency situations*. They require that the "Good Samaritan" use common sense and a reasonable level of skill, not to exceed the scope of the individual's training in emergency situations. They assume each person would do his or her best to save a life or prevent further injury.

People are rarely sued for helping in an emergency. However, the existence of Good Samaritan laws does not mean that someone cannot sue. In rare cases, courts have ruled that these laws do not apply in cases when an individual rescuer's response was grossly or willfully negligent or reckless or when the rescuer abandoned the victim after initiating care.

### **Permission to Give Care**

If the victim is conscious, you must have his/her permission before giving first-aid. To get permission you *must* tell the victim who you are, how much training you have, and how you plan to help. Only then can a conscious victim give you permission to give care.

***Do not give care to a conscious victim who refuses your offer to give care.***

If the conscious victim is an infant or child, permission to give care should be obtained from a supervising adult when one is available. If the condition is serious, permission is implied if a supervising adult is not present.

Permission is also implied if a victim is unconscious or unable to respond. This means that you can assume that, if the person could respond, he or she would agree to care.

### **Treatment at Site**

#### **WHAT TO DO**

**Access** the injury. If the victim is conscious, find out what happened, where it hurts, watch for shock.

**Know** your limitations.

**Call 9-1-1** immediately if person is unconscious or seriously injured.

**Look** for signs of injury (blood, black-and-blue, deformity of joint, etc.)

**Listen** to the injured player describe what happened and what hurts if conscious. Before questioning, you may have to calm and soothe an excited child.

**Feel** gently and carefully the injured area for signs of swelling or grating of broken bone.

**Talk** to your team afterwards about the situation if it involves them. Often players are upset and worried when another player is injured. They need to feel safe and understand why the injury occurred.

#### **WHAT NOT TO DO . . .**

**Administer** any medications.

**Provide** any food or beverages (other than water).

**Hesitate** in giving aid when needed.

**Be afraid** to ask for help if you're not sure of the proper procedure, (e.g., CPR, etc.)

**Transport** injured individual except in extreme emergencies.

### **When to Call 9-1-1**

If the injured person is unconscious, call **9-1-1** immediately. Sometimes a conscious victim will tell you to not call an ambulance, and you may not be sure what to do. Call **9-1-1** anyway and request paramedics if the victim:

- Is or becomes unconscious.
- Has trouble breathing or is breathing in a strange way.
- Has chest pain or pressure.
- Is bleeding severely.
- Has pressure or pain in the abdomen that does not go away.
- Is vomiting or passing blood.
- Has seizures, a severe headache, or slurred speech.
- Appears to have been poisoned.
- Has injuries to the head, neck or back.
- Has possible broken bones.

If you have any doubts, call **9-1-1** and request paramedics. Do call **9-1-1** for any of these situations:

- Fire or explosion
- Downed electrical wires
- Swiftly moving or rapidly rising water
- Presence of poisonous gas
- Vehicle collisions
- Vehicle/bicycle collisions
- Victims who cannot be moved easily

### **Proper Protocol When Calling 9-1-1**

The most important help that you can provide to a victim who is seriously injured is to call for professional medical help.

Make the call quickly, preferably from a cell phone near the injured person. If this is not possible, send someone else to make the call from a nearby telephone.

- First Dial **9-1-1**.
- Give the dispatcher the necessary information. Answer any questions that he or she might ask. Most dispatchers will ask the exact location or address of the emergency. Include the name of the city or town, nearby intersections, landmarks, etc. The league's physical address is: **11609 Clay Pit Road, Seffner, Florida**
- The telephone number from which the call is being made and the caller's name.
- What happened (e.g., a baseball related injury, bicycle accident, fire, fall, etc.).
- How many people are involved.
- The condition of the injured person (e.g., unconsciousness, chest pains, or severe bleeding).
- What help (first aid) is being given.

- Do not hang up until the dispatcher hangs up. The EMS dispatcher may be able to tell you how to best care for the victim.
- Continue to care for the victim till professional help arrives.
- Appoint somebody to go to the street and look for the ambulance and fire engine and flag them down if necessary. This saves valuable time.

### **Remember—every minute counts!**

#### **Checking a Conscious Victim**

If the victim is conscious, ask what happened. Look for other life-threatening conditions or conditions that need care or might become life-threatening. The victim may be able to tell you what happened and how he/she feels. This information helps determine what care may be needed. This check has several steps:

1. Talk to the victim and to any people standing by who saw the accident take place.
2. Check the victim from head-to-toe, so you do not overlook any problems.
3. Do not ask the victim to move, and do not move the victim yourself.
4. Examine the scalp, face, ears, nose, and mouth.
5. Look for cuts, bruises, bumps, or depressions.
6. Watch for changes in consciousness.
7. Notice if the victim is drowsy, not alert, or confused.
8. Look for changes in the victim's breathing. A healthy person breathes regularly, quietly, and easily. Breathing that is not normal includes noisy breathing such as gasping for air; making rasping, gurgling, or whistling sounds; breathing unusually fast or slow; and breathing that is painful.
9. Notice how the skin looks and feels. Note if the skin is reddish, bluish, pale or gray.
10. Feel with the back of your hand on the forehead to see if the skin feels unusually damp, dry, cool, or hot.
11. Ask the victim again about the areas that hurt.
12. Ask the victim to move each part of the body that doesn't hurt.
13. Check the shoulders by asking the victim to shrug them.
14. Check the chest and abdomen by asking the victim to take a deep breath.
15. Ask the victim if he or she can move the fingers, hands, and arms.
16. Check the hips and legs in the same way.
17. Watch the victim's face for signs of pain and listen for sounds of pain such as gasps, moans or cries.

18. Look for odd bumps or depressions. Think of how the body usually looks. If you are not sure that something is out-of-shape, check it against the other side of the body.
19. Look for a medical alert tag on the victim's wrist or neck. A tag will give you medical information about the victim, care to give for that problem, and who to call for help.
20. When you have finished checking, if the victim can move his or her body without any pain and there are no other signs of injury, have the victim rest sitting-up.
21. When the victim feels ready, help him or her stand up.

### **Checking an Unconscious Victim**

If the victim does not respond to you in any way, assume the victim is unconscious. Call **9-1-1** and report the emergency immediately.

1. Tap and shout to see if the person responds. If no response:
  - Look, listen and feel for breathing for about 5 seconds.
  - If there is no response, position victim on back, while supporting head and neck.
2. Tilt head back, lift chin and pinch nose shut.
3. Look, listen, and feel for breathing for about 5 seconds.
4. If the victim is not breathing, give 2 slow breaths into the victim's mouth.
5. Check pulse for 5 to 10 seconds.
6. Finger sweep maneuver administered to an unconscious victim of foreign body airway obstruction.



## **Muscle, Bone, or Joint Injuries**

### **Serious Symptoms**

Always suspect a serious injury when the following signals are present:

- Significant deformity
- Bruising and swelling
- Inability to use the affected part normally
- Bone fragments sticking out of a wound
- Victim feels bones grating; victim felt or heard a snap or pop at the time of injury
- The injured area is cold and numb
- Cause of the injury suggests that the injury may be severe.



If any of these conditions exists, call **9-1-1** immediately and administer care to the victim until the paramedics arrive.



### **Treatment for Muscle or Joint Injuries**

- If ankle or knee is affected, do not allow victim to walk. Loosen or remove shoe; elevate leg.
- Protect skin with thin towel or cloth. Then apply cold, wet compresses or cold packs to affected area. Never pack a joint in ice or immerse in icy water.
- If a twisted ankle, do not remove the shoe—this will limit swelling.
- Consult professional medical assistance for further treatment if necessary.

### **Treatment for Fractures**

Fractures need to be splinted in the position found and no pressure is to be put on the area. Splints can be made from almost anything; rolled up magazines, twigs, bats, etc.

### **Treatment for Broken Bones**

Once you have established that the victim has a broken bone, and you have called **9-1-1**, all you can do is comfort the victim, keep him/her warm and still and treat for shock if necessary (see **Shock**).



### **Osgood Schlaughters Disease**

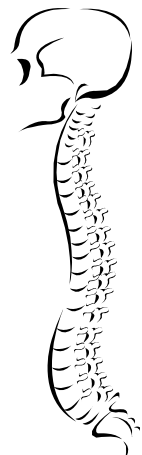
Osgood Schlaughters Disease is the “growing pains” disease. It is very painful for kids that have it. In a nutshell, the bones grow faster than the muscles and ligaments and the child will complain of pain in the arms and legs. Children will outgrow this disease. All you can do is make it easier for him or her by:

1. Icing the painful areas.
2. Making sure the child rests when needed.
3. Using Ace or knee supports.

## **Head and Spine Injuries**

### **When to suspect head and spine injuries**

- A fall from a height greater than the victim’s height.
- Any bicycle, skateboarding, rollerblade mishap.
- A person found unconscious for unknown reasons.
- Any injury involving severe blunt force to the head or trunk, such as from a bat or line drive baseball.
- Any injury that penetrates the head or trunk, such as impalement.
- A motor vehicle crash involving a driver or passengers not wearing safety belts.
- Any person thrown from a motor vehicle.
- Any person struck by a motor vehicle.
- Any injury in which a victim’s helmet is broken, including a motorcycle, batting helmet, industrial helmet.
- Any incident involving a lightning strike.



### **Signals of Head and Spine Injuries**

- Changes in consciousness
- Severe pain or pressure in the head, neck, or back
- Tingling or loss of sensation in the hands, fingers, feet, and toes
- Partial or complete loss of movement of any body part
- Unusual bumps or depressions on the head or over the spine
- Blood or other fluids in the ears or nose
- Heavy external bleeding of the head, neck, or back
- Seizures
- Impaired breathing or vision as a result of injury
- Nausea or vomiting
- Persistent headache
- Loss of balance
- Bruising of the head, especially around the eyes and behind the ears.

### **General Care for Head and Spine Injuries**

- Call **9-1-1** immediately.
- Minimize movement of the head and spine.
- Maintain an open airway.
- Check consciousness and breathing.
- Control any external bleeding.
- Keep the victim from getting chilled or overheated until paramedics arrive and take over care.

## **Concussions**

### **Understanding Concussion**

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes your head and brain to move rapidly back and forth.

This sudden movement can literally cause the brain to bounce around or twist in the skull, stretching and damaging the brain cells and creating chemical changes in the brain.

What you might not know is that these chemical changes make the brain more vulnerable to further injury. During this window of vulnerability the brain is more sensitive to any increased stress or injury, until it fully recovers.

Unlike a broken arm, or other injuries that you can feel with your hands or see on an x-ray, you can't see a concussion. It is a disruption of how the brain works. It is not a "bruise to the brain." That is why brain CAT scans and MRIs are normal with most concussions.

### **Causes of Concussion**

- A knock to the head from a fall...
- A jolt to the torso from a collision...
- A hit to the head from a stick or ball...

A concussion can occur from any type of contact such as colliding with a player, a goalpost, the ground, or another obstacle. Concussions can also occur outside of sports, ranging from bumping your head on a door to being in a car crash.

**Don't be fooled!** Even what may seem like a mild bump to the head can actually be serious.

### **Potential Consequences of a Concussion**

Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

Not giving the brain enough recovery time after a concussion can be dangerous. A repeat concussion that occurs before the brain recovers from the first—usually within a short time period (hours, days, weeks)—can slow recovery or increase the chances for long-term problems. In rare cases, repeat concussions can result in brain swelling or permanent brain damage. It can even be fatal.

Yes, while rare, permanent brain damage and death are two potential consequences of not identifying and responding to a concussion in a proper or timely manner.

That's why it is incredibly important for you to pull an athlete from play if you suspect he or she has a concussion.

### **Did You Know?**

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

### **What to Watch for**

As a coach you're the first defense, ready to jump in to help if something seems "off"—even when an athlete doesn't know it or want to admit it.

Remember, you can't see a concussion, like you can see a broken arm, and there is no one single indicator for concussion. Instead, recognizing a concussion requires watching for different types of signs or symptoms.

So to help recognize a concussion, you should watch for and ask others to report the following two things among your athletes:

1. A forceful bump, blow, or jolt to the head or body that results in rapid movement of the head. —and—
2. Any concussion signs or symptoms, such as a change in the athlete's behavior, thinking, or physical functioning.

Keep the following list of signs and symptoms on hand. Athletes who exhibit or report **one or more** of the signs and symptoms listed below, or simply say they just “don’t feel right” after a bump, blow, or jolt to the head or body, may have a concussion.

Signs and symptoms of concussion generally show up soon after the injury. But the full effect of the injury may not be noticeable at first and some symptoms may not show up for hours or days. For example, in the first few minutes the athlete might be slightly confused or appear a little bit dazed, but an hour later they can’t recall coming to the practice, game, or event.

So assess the player, then assess the player again. Make sure that the athlete is supervised for at least one or two hours after you suspect a concussion. Also, talk to the athlete’s parents about watching for symptoms at home and when the athlete returns to school.

The key is to keep a list of concussion signs and symptoms in your clipboard, and to use it while repeatedly checking on your athlete with a suspected concussion. You can order CDC’s free “Heads Up” materials with concussion signs and symptoms to place on your clipboard for all practices and games, and post in the locker rooms.

<b>SIGNS OBSERVED BY COACHING STAFF</b>	<b>SYMPTOMS REPORTED BY ATHLETES</b>
Appears dazed or stunned	Headache or “pressure” in head
Is confused about assignment or position	Nausea or vomiting
Forgets an instruction	Balance problems or dizziness
Is unsure of game, score, or opponent	Double or blurry vision
Moves clumsily	Sensitivity to light
Answers questions slowly	Sensitivity to noise
Loses consciousness (even briefly)	Feeling sluggish, hazy, foggy, or groggy
Shows mood, behavior, or personality changes	Concentration or memory problems
Can’t recall events prior to hit or fall	Confusion
Can’t recall events after hit or fall	Just not “feeling right” or “feeling down”

### **Danger Signs**

If the signs or symptoms get worse, you need to consider it a medical emergency.

In rare cases, a dangerous blood clot may form on the brain in an athlete with a concussion and squeeze the brain against the skull. Call 9-1-1 or take the athlete to the emergency department right away if after a bump, blow, or jolt to the head or body, he or she exhibits **one or more** of the following danger signs:

- One pupil larger than the other
- Drowsiness or inability to wake up
- A headache that gets worse and does not go away
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures

- Inability to recognize people or places
- Increasing confusion, restlessness, or agitation
- Unusual behavior
- Loss of consciousness (even a brief loss of consciousness should be taken seriously)

### **When You Suspect a Concussion**

Pulling someone out of the middle of a practice, game, or event is never an easy thing, especially if an athlete tells you that nothing is wrong.

But we know that your top priority is keeping your athletes safe and preparing them for the future—both on and off the field.

That's why we encourage you to follow these steps, which are part of CDC's "Heads Up" four-step action plan:

1. **Remove the athlete from play.** Look for the signs and symptoms of a concussion, if your athlete has experienced a bump or blow to the head or body. When in doubt, sit them out.
2. **Ensure that the athlete is evaluated by a health care professional experienced in evaluating for concussion.** Do not try to judge the severity of the injury yourself. Health care professionals have a number of methods that they can use to assess the severity of concussions. As a coach, recording the following information can help health care professionals in assessing the athlete after the injury:
  - Cause of the injury and force of the hit or blow to the head or body
  - Any loss of consciousness (passed out/knocked out) and if so, for how long
  - Any memory loss immediately following the injury
  - Any seizures immediately following the injury
  - Number of previous concussions (if any)
3. **Inform the athlete's parents or guardians** about the possible concussion and give them the CDC fact sheet on concussion for parents. This fact sheet can help parents monitor the athlete for sign or symptoms that appear or get worse once the athlete is at home or returns to school.
4. **Keep the athlete out of play the day of the injury** and until a health care professional, experienced in evaluating for concussion, says it's OK for the athlete to return. In the case of suspected concussion, the decision about when to return to practice or play is a medical decision.

### **"Toughing It Out" Isn't Strong—It's Dangerous**

Sometimes people believe that it shows strength and courage to play when you're injured. Not only is that belief wrong, it can put a young athlete at risk for serious injury.

Don't let others—fans, parents, or teammates—pressure you or the injured athlete to continue playing. As you've probably experienced, some athletes may try telling you that s/he is "just fine" or that s/he can "tough it out."

Tell them that taking a time out is not a sign of weakness, and that playing with a concussion is dangerous. Don't shy away from sharing this information with parents and other team supporters, either.

## Contusions

A contusion is commonly called a **bruise** and can be identified by a dark discoloration of the skin. The area in which the injury has occurred will become black and blue due to small blood vessels in the area rupturing and bleeding into the tissue around the injury. The bleeding may cause swelling, which is the second sign of a contusion.



The most common cause of a contusion for Little League players is being hit with the ball. Contusions can also be caused by being hit with the bat, a player falling and hitting the ground, sliding into another player or running into a hard object.

If a player complains of pain over an area after a hard blow, the Manager or Coach should:

- Look for swelling in the area and/or discoloration of the body tissue in the area.
- Feel the area for tenderness.
- Have the player try to move the injured area. Try to determine how much pain is associated with the movement. Extreme pain could indicate a severe injury.

### TREATMENT

1. Apply ice or a cold pack to the area.
2. Notify parents.
3. Recommend to the parent that a physician be contacted if the contusion is moderate or severe.

### Contusion to Sternum

Contusions to the sternum are usually the result of a line drive that hits a player in the chest. These injuries can be very dangerous because if the blow is hard enough, the heart can become bruised and start filling up with fluid. Eventually the heart is compressed and the victim dies. *Do not downplay the seriousness of this injury.*

- If a player is hit in the chest and appears to be all right, urge the parents to take their child to the hospital for further examination.
- If a player complains of pain in his chest after being struck, immediately call **9-1-1** and treat the player until professional medical help arrives.
- Pull a player from the game or practice if the contusion produces moderate to severe pain on movement.

## Sudden Illness

When a victim becomes suddenly ill, he or she often looks and feels sick. Symptoms of sudden illness include:

- Feeling light-headed, dizzy, confused, or weak
- Changes in skin color (pale or flushed skin), sweating
- Nausea or vomiting
- Diarrhea
- Changes in consciousness
- Seizures
- Paralysis or inability to move
- Slurred speech
- Impaired vision
- Severe headache
- Breathing difficulty
- Persistent pressure or pain.

### Care for Sudden Illness

1. Call **9-1-1**.
2. Help the victim rest comfortably.
3. Keep the victim from getting chilled or overheated.
4. Reassure the victim.
5. Watch for changes in consciousness and breathing.
6. Do not give anything to eat or drink unless the victim is fully conscious.

If the victim:

**Vomits** – Place the victim on his or her side.

**Faints** – Position him or her on the back and elevate the legs 8 to 10 inches if you do not suspect a head or back injury.

**Has a diabetic emergency** – Give the victim some form of sugar.

**Has a seizure** – Do not hold or restrain the person or place anything between the victim's teeth. Remove any nearby objects that might cause injury. Cushion the victim's head using folded clothing or a small pillow.

## Shock

Shock is likely to develop in any serious injury or illness. Signals of shock include:

- Restlessness or irritability
- Altered consciousness
- Pale, cool, moist skin
- Rapid breathing
- Rapid pulse.

Caring for shock involves the following steps:

1. Have the victim lie down. Helping the victim rest comfortably is important because pain can intensify the body's stress and accelerate the progression of shock.
2. Control any external bleeding.
3. Help the victim maintain normal body temperature. If the victim is cool, try to cover him or her to avoid chilling.
4. Try to reassure the victim.
5. Elevate the legs about 12 inches unless you suspect head, neck, or back injuries or possible broken bones involving the hips or legs. If you are unsure of the victim's condition, leave him or her lying flat.
6. Do not give the victim anything to eat or drink, even though he or she is likely to be thirsty.
7. Call 9-1-1 immediately. Shock can't be managed effectively by first-aid alone. A victim of shock requires advanced medical care as soon as possible.

## **Breathing Problems**

If the person is not breathing:

1. Position the individual on their back while supporting head and neck.
2. With the person's head tilted back and chin lifted, pinch the nose shut.
3. Give two (2) slow breaths into person's mouth. Breathe in until chest gently rises.
4. Check for a pulse at the carotid artery (use fingers instead of thumb).
5. If pulse is present but person is still not breathing give one slow breath about every 5 seconds. Do this for about one minute (12 breaths).
6. Continue rescue breathing as long as a pulse is present but person is not breathing.

Once a victim requires emergency breathing you become the life support for that person—without you the victim would be clinically dead. You must continue to administer emergency breathing and/or CPR until the paramedics get there. It is your obligation and you are protected under the "Good Samaritan" laws.

### **If Not Breathing and Air Won't Go In**

1. Re-tilt person's head.
2. Give breaths again.
3. If air still won't go in, place the heel of one hand against the middle of the person's abdomen just above the navel.
4. Give up to five abdominal thrusts.
5. Lift jaw and tongue and sweep out mouth with your fingers to free any obstructions.
6. Tilt head back, lift chin, and give breaths again.



7. Repeat breaths, thrust, and sweeps until breaths go in.

## Heart Attack

Heart attack pain is most often felt in the center of the chest, behind the breastbone. It may spread to the shoulder, arm or jaw. Signals of a heart attack include:

- Persistent chest pain or discomfort - Victim has persistent pain or pressure in the chest that is not relieved by resting, changing position, or oral medication. Pain may range from discomfort to an unbearable crushing sensation.
- Breathing difficulty
  - Victim's breathing is noisy.
  - Victim feels short of breath.
  - Victim breathes faster than normal.
- Changes in pulse rate – Pulse may be faster or slower than normal; pulse may be irregular.
  - Skin appearance may be pale or bluish in color.
  - Victim's face may be moist.
  - Victim may perspire profusely.
  - Absence of pulse - Main signal of a cardiac arrest.

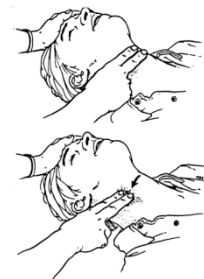


The number one indicator that someone is having a heart attack is that he or she will be in denial. A heart attack means certain death to most people. People do not wish to acknowledge death therefore they will deny that they are having a heart attack. Convince the victim to stop activity and rest.

### Heart Attack Care

#### **If the person is unconscious:**

- Are they breathing? Look at the patient's chest to see if it is rising and falling.
- Do they have a pulse? Place two fingers on one or other side of the person's voice box in their throat to feel if they have a carotid pulse.



#### **If the patient has a pulse but is not breathing:**

- Could it be because of suffocation? Feel inside the mouth with a finger to see if there is anything blocking it or the windpipe and remove any food or other objects. Provided that dentures are not broken, it is better not to remove them.
- Call for help immediately, stating that the casualty is not breathing, and provide resuscitation (see Giving CPR) until the patient begins to breathe or the ambulance arrives.

#### **If the person is conscious:**

- Help the victim to rest comfortably.
- Try to obtain information about the victim's condition.

- Comfort the victim.
- Call 9-1-1 and report the emergency.
- Assist with medication, if prescribed.
- Monitor the victim's condition.

Be prepared to give CPR if the victim's heart stops beating.

## Choking

### Partial Obstruction with Good Air Exchange

Symptoms may include forceful cough with wheezing sounds between coughs.

#### **TREATMENT:**

Encourage victim to cough as long as good air exchange continues.

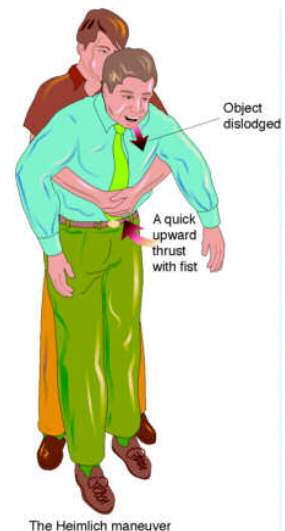
**Do not** interfere with attempts to expel the object.

### Partial or Complete Airway Obstruction in Conscious Victim

Symptoms may include: Weak cough; high-pitched crowing noises during inhalation; inability to breathe, cough or speak; gesture of clutching neck between thumb and index finger; exaggerated breathing efforts; dusky or bluish skin color.

#### **TREATMENT – THE HEIMLICH MANEUVER:**

1. Stand behind the victim.
2. Reach around victim with both arms under the victim's arms.
3. Place thumb side of fist against middle of abdomen just above the navel. Grasp fist with other hand.
4. Give quick, upward thrusts.
5. Repeat until object is coughed up.



#### **FOR A CHILD:**

1. Place your hands at the top of the pelvis;
2. Put the thumb of your hand at the pelvis line;
3. Put the other hand on top of the first hand;
4. Pull forcefully back as many times as needed to get object out or the child becomes limp.

Most individuals are fine after the object is removed from the airway.

However, occasionally the object will go into one of the lungs. If there is a possibility that the foreign object was not expelled, medical care should be sought.



If the object cannot be removed completely by performing the Heimlich, immediate medical care should be sought by calling 911 or going to the local emergency room.

## Giving CPR

CPR (cardiopulmonary resuscitation) is used when a person stops breathing (respiratory arrest) and his heart has stopped beating (cardiac arrest). Giving CPR may start their breathing and heart beating again. If you start CPR early and do it correctly, you may be able to save someone from dying. **Adult CPR should be used on people over the age of 8 years old.**

When a person is not breathing but his heart is still beating, rescue breathing is done. Rescue breathing means breathing for the person by giving him rescue breaths. When a person's heart is not beating, chest compressions are done. A chest compression is the placement of pressure on and off the chest with your hand. A compression presses the heart between the spine (backbone) and sternum (breastbone). This forces blood out of the heart and into the rest of the body. When rescue breathing is done with chest compressions, it is called CPR.

### **When Would Someone Need CPR?**

- A heart attack is the most common reason why an adult would need CPR. A heart attack happens when part of the heart muscle dies because it does not have oxygen.
- Drug overdose.
- Choking.
- Lightning strike.
- Stroke (blood supply to part of the brain is stopped).
- Breathing in smoke, like when you are trapped in a fire.
- Drowning.

### **Why is it important to begin CPR as soon as possible?**

When a person stops breathing, their heart may continue to beat for several minutes. After that, the heart will not beat, and brain damage is possible. Brain damage happens because there is no oxygen going to the brain. To avoid brain damage, you should always begin the steps of CPR right away. Depending on the medical condition or reason why the person needs CPR, doing CPR may save their life.

Survey the scene, then **RAP**:

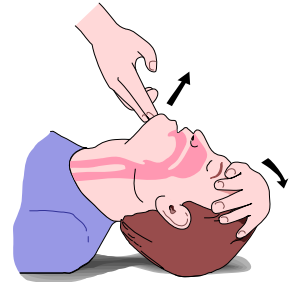
- **R**esponsiveness – Tap victim on shoulder and shout “Are you okay?”
- **A**ctivate EMS – *Always call or send someone to call 9-1-1 before starting rescue breathing or CPR.*
- **P**osition on back – Roll all body parts over at the same time. Be aware of head/spinal cord injuries; support neck and spinal column.



## **The ABC's of CPR (Airway, Breathing & Circulation)**

### **AIRWAY:**

1. Kneel beside the person and check to see if their head, neck, or back may have been injured. Moving a person with a broken neck or back could cause them to become paralyzed. Turn the person carefully onto their back, while twisting) as you turn the person onto his back.
2. For no visible signs of head or neck injury: Open the person's airway by tilting the head back and lifting the chin. Put one hand on the person's forehead and press firmly backward to tilt the head back. Do not place your hand on the back of the neck to tilt the head. Put the fingers of the other hand under the chin and lift the chin forward. Keep the person's mouth open. Do not press deeply into the soft tissue under the chin because this can close the airway.
3. For visible signs of head or neck injury: Place the fingers of each of your hands on either side of the person's lower jaw. Lift the jaw forward with both hands to open the airway.



### **BREATHING:**

4. **Check for breathing:** Look, listen and feel for breathing while keeping the airway open. Put your ear close to the person's mouth and nose. Look at the person's chest to see if it goes up and down with breathing. Listen for the sounds of breathing. Feel for any air movement on your cheek.
  - If the person is breathing and there are no signs of injury, carefully turn the person on his side. Support the head and neck as you turn the person onto his side. This is called the recovery position. It may help to keep a person from choking if he throws up. Wait for trained caregivers to arrive.
  - If the person is breathing and there are signs of injury, leave the person on his back and hold the airway open using the jaw thrust. Wait for 911 help to arrive.

It is possible that you will break the victim's ribs while administering CPR. Do not be concerned about this. The victim is clinically dead without your help. You are protected under the "Good Samaritan" laws.

5. **Rescue breathing:** If the person is not breathing normally, you must breathe for him.
6. Keep the airway open by the tilting the head back and lifting the chin. Use the jaw thrust for a person with a possible head or neck injury.
7. Gently pinch the nose closed using the hand on the person's forehead. This stops air from escaping through the nose. If using the jaw thrust, seal the nose by pressing your cheek tightly against the person's nostrils. Take a deep breath and put your lips around the person's mouth making an airtight seal.
8. Give two slow breaths (about 2 seconds for each breath) into the person's mouth. Take a breath for yourself after each breath that you give.

9. The person's chest should rise each time you give a rescue breath. The airway may not be open if you do not see the chest go up and down with each breath. Change the person's head position to reopen the airway and try to rescue breathe for him again. If you still cannot get air into the person, the airway may be blocked by something like food. Look into the person's mouth to check if there is something that may be blocking the airway. If you see something, scoop it out with your finger.

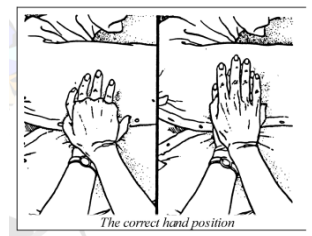


### **CIRCULATION:**

10. **Check for circulation:** After giving rescue breaths, check for signs of circulation. Signs of circulation are breathing (not gasping), coughing or moving. With your ear next to the person's mouth, look, listen and feel for breathing. Look for any movement in the person's body. If the person is not breathing, coughing, or moving, you should immediately begin chest compressions. Do not take more than 10 seconds to check for signs of circulation.

### **Hand Positioning for Chest Compressions**

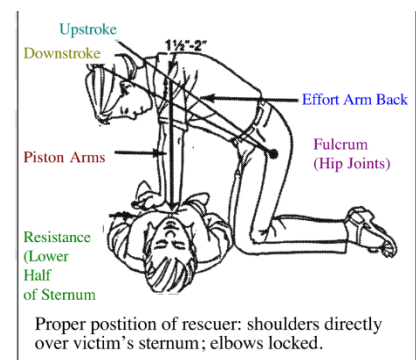
1. Put the fingers of your hand on the person's lower rib cage on the side nearest you. Move your fingers up the rib cage to the place where the ribs meet in the middle of the chest. This area is called the sternum.



2. Put the heel of one hand on the lower half of the sternum (at the nipple line) and put the heel of the other hand on top of it.
3. Lace your fingers together or extend them above the chest. Do not lay your fingers on the chest. By laying your fingers on the chest, you may do compressions in the wrong place. Incorrect hand positioning can break the ribs during compressions.
4. Lock your elbows with your arms straight. Your shoulders should be directly over the center of the person's chest. Look down at your hands.

### **CHEST COMPRESSIONS**

1. Press down on the sternum about 1½ to 2 inches. The compressions should be constant and equal. This means that it should take the same amount of time to press down as it does to release the compression. Allow the chest to relax between compressions while leaving your hands on the chest in the correct hand position. This allows blood to come back into the heart before you compress again.
2. Do 15 chest compressions at a rate of about 100 every minute (almost 2 compressions per second). Count "one and, two and, three and, four and, five and, six and, seven



and, eight and, nine and, ten, eleven, twelve, thirteen, fourteen, fifteen." Counting this out loud may help you do the compressions at a steady, even speed. It may also help you remember how many compressions you have done.

### **Putting It All Together**

1. After doing 15 compressions, quickly move up to the person's head. Open the airway by tilting the head and lifting the chin. If you think there is a head or neck injury, open the airway by lifting the jaw. Give 2 slow rescue breaths (about 2 seconds for each breath).
2. Continue giving 15 compressions and 2 rescue breaths for 4 cycles. Next, look for signs of circulation in the person (breathing, coughing or moving). If there are no signs of circulation, continue doing 15 compressions and 2 breaths in cycles. Re-check for signs of circulation again after 4 cycles of compressions and rescue breaths.
  - If you see signs of circulation, but the **person is not breathing**, perform rescue breathing. In this case, you do not need to do chest compressions. In rescue breathing, give 1 breath every 4 to 5 seconds. Check for signs of circulation every couple of minutes to see if the person's heart is still beating on its own.
  - If there are signs of circulation and the person is breathing, you can stop doing CPR. Carefully turn the person on his side if there are **no signs of head or neck injury**. Support the head and neck as you turn the person onto his side. This is called the recovery position. Being in this position will prevent him from choking if he begins to throw up. If **there are signs of injury**, leave the person on his back and hold the airway open using the jaw thrust. Stay with the person and watch him closely until trained caregivers arrive.



### **When to Stop CPR**

- When another trained person takes over CPR for you.
- When Paramedics arrive and take over care of the victim.
- When you are exhausted and unable to continue.
- When the scene suddenly becomes unsafe, such as the start of a fire.
- When the person's heart starts beating again. If breathing does not start once the heart starts beating again, do only rescue breathing. If both breathing and a heart beat start, keep the person's airway open. Check for breathing and signs of circulation often while waiting for trained caregivers to arrive.

## **Transporting An Injured Person**

If an injury involves the neck or back, **do not** move the victim unless absolutely necessary; wait for paramedics. If the victim must be pulled to safety, move their body lengthwise, not sideways.

If possible, slide a coat or blanket under the victim using the following procedures:

1. Carefully turn victim toward you and slip a half-rolled blanket under back.
2. Turn victim on side over blanket, unroll, and return victim onto back.
3. Drag victim head first, keeping back as straight as possible.

If a victim must be lifted, use the following steps:

1. Support each part of the body.
2. Position a person at victim's head to provide additional stability.
3. Use a board, shutter, tabletop or other firm surface to keep body as level as possible.

## External Bleeding

Before initiating any First Aid to control bleeding, be sure to wear the **latex gloves** included in your First-Aid Kit in order to avoid contact of the victim's blood with your skin. If a victim is bleeding:

1. **Act quickly.** Have the victim lie down. Elevate the injured limb higher than the victim's heart unless you suspect a broken bone.
2. **Control bleeding** by applying direct pressure on the wound with a sterile pad or clean cloth.
3. If bleeding is controlled by direct pressure, **bandage firmly** to protect wound. Check pulse to be sure bandage is not too tight.
4. If bleeding is not controlled by use of direct pressure, **apply a tourniquet** only as a last resort and call **9-1-1** immediately.

## Nose Bleed

To control a nose bleed:

- Breathe through the mouth, not the nose.
- Sit up and bend the head slightly forward.
- Pinch the nostrils together for at least 10 minutes until bleeding stops. At the same time, apply cold compresses (such as ice in a soft cloth) to the area around the nose.
- For the next 24 hours, make sure the head is elevated above the level of your heart.
- Also, wait 24 hours before blowing the nose, lifting heavy objects, or exercising strenuously.

## Bleeding On the Inside/Outside of the Mouth

To control bleeding inside the cheek, place folded dressings inside the mouth against the wound.

To control bleeding on the outside, use dressings to apply pressure directly to the wound and bandage so as not to restrict.

### **Deep Cuts**

If the cut is deep, stop bleeding, bandage, and encourage the victim to get to a hospital so he/she can be stitched up. **Stitches prevent scars.**

### **Infection**

To prevent infection when treating open wounds you must:

- **CLEANSE...** the wound and surrounding area gently with mild soap and water or an antiseptic pad; rinse and blot dry with a sterile pad or clean dressing.
- **TREAT...** to protect against contamination with ointment supplied in your First-Aid Kit.
- **COVER...** to absorb fluids and protect wound from further contamination with Band-Aids, gauze, or sterile pads supplied in your First-Aid Kit. (Handle only the edges of sterile pads or dressings)
- **TAPE...** to secure with First-Aid tape (included in your First-Aid Kit) to help keep out dirt and germs.

### **Penetrating Objects**

If an object, such as a knife or a piece of glass or metal, is impaled in a wound:

1. **Do not remove it.**
2. Place several dressings around object to keep it from moving.
3. Bandage the dressings in place around the object.
4. If object penetrates chest and victim complains of discomfort or pressure, quickly loosen bandage on one side and reseal. Watch carefully for recurrence. Repeat procedure if necessary.

Treat for shock if needed (see **Shock**). Call **9-1-1** for professional medical care.

### **Splinters**

Splinters are defined as slender pieces of wood, bone, glass or metal objects that lodge in or under the skin. If splinter is in eye, **do not** remove it. Symptoms may include pain, redness and/or swelling.



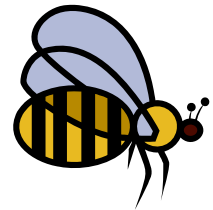
**TREATMENT:**

1. First wash your hands thoroughly, then gently wash affected area with mild soap and water.
2. Sterilize needle or tweezers by boiling for 10 minutes or heating tips in a flame; wipe off carbon (black discoloration) with a sterile pad before use.
3. Loosen skin around splinter with needle; use tweezers to remove splinter. If splinter breaks or is deeply lodged, consult professional medical help.
4. Cover with adhesive bandage or sterile pad, if necessary.

## **Insect Stings**

In highly sensitive persons, do not wait for allergic symptoms to appear. Get professional medical help immediately. Call **9-1-1**. If breathing difficulties occur, start rescue breathing techniques; if pulse is absent, begin CPR.

Symptoms and signs of allergic reaction may include: nausea; severe swelling; breathing difficulties; bluish face, lips and fingernails; shock or unconsciousness.



**TREATMENT:**

1. Remove stinger or venom sac by gently scraping with fingernail or business card. (This applies to bees only; yellow jackets, wasps and hornets don't lose their stingers.) Do not remove stinger with tweezers as more toxins from the stinger could be released into the victim's body.
2. Keep a container of meat tenderizer (like Ac'cent) in the Concession stand. Apply a paste of the meat tenderizer to the sting area. The enzymes in the meat tenderizer can break down the protein in the venom.
3. For multiple stings, soak affected areas in cool water. Add one tablespoon of baking soda per quart of water. Use the meat tenderizer paste.

## **Dismemberment**

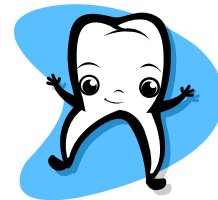
If a part of the body has been torn or cut off:

1. Try to find the body part and wrap it in sterile gauze or any clean material, such as a washcloth.
2. Put the wrapped body part in a plastic bag.
3. Keep the body part cool by placing the bag on ice, if possible, but do not freeze.
4. Be sure the body part is taken to the hospital with the victim, as doctors may be able to reattach it.

## Emergency Treatment o/f Dental Injuries

### Entire Tooth Knocked Out

1. Place a sterile dressing directly in the space left by the tooth. Tell the victim to bite down. Dentists can successfully replant a knocked-out tooth if they can do so quickly and if the tooth has been cared for properly.
2. Avoid additional trauma to tooth while handling.
  - **Do not** handle tooth by the root.
  - **Do not** brush or scrub tooth.
  - **Do not** sterilize tooth.
  - If debris is on tooth, gently rinse with water.
3. If possible, re-implant and stabilize by biting down gently on a towel or handkerchief. **Do only** if athlete is alert and conscious.
4. If unable to re-implant:
  - **Best** - Place tooth in *Hank's Balanced Saline Solution* (i.e., *Savea-tooth*.)
  - **2nd best** - Place tooth in milk. Cold whole milk is best, followed by cold 2% milk.
  - **3rd best** - Wrap tooth in saline soaked gauze.
  - **4th best** - Place tooth under victim's tongue. Do only if athlete is conscious and alert.
  - **5th best** - Place tooth in cup of water.
5. Time is very important. Re-implantation within 30 minutes has the highest degree of success rate.
6. Transport immediately to dentist.



### Tooth in Socket, but Wrong Position

**Extruded Tooth** - Upper tooth hangs down and/or lower tooth raised up:

1. Reposition tooth in socket using firm finger pressure.
2. Stabilize tooth by gently biting on towel or handkerchief.
3. Transport immediately to dentist.
4. Lateral Displacement - Tooth pushed back or pulled forward:
5. Try to reposition tooth using finger pressure.
6. Victim may require local anesthetic to reposition tooth; if so, stabilize tooth by gently biting on towel or handkerchief.
7. Transport immediately to dentist.

**Intruded Tooth** - Tooth pushed into gum; looks short.

1. Do nothing - avoid any repositioning of tooth.
2. Transport immediately to dentist.

### **Fracture (Broken Tooth)**

1. If tooth is totally broken in half, save the broken portion and bring to the dental office as described under Entire Tooth Knocked Out, Item 4.
2. Stabilize portion of tooth left in mouth by gently biting on a towel or handkerchief to control bleeding.
3. Should extreme pain occur, limit contact with other teeth, air or tongue. Pulp nerve may be exposed, which is extremely painful to athlete.
4. Save all fragments of fractured tooth as described under Entire Tooth Knocked Out, Item 4.
5. Immediately transport patient and tooth fragments to dentist in the plastic baggie supplied in your First-Aid kit.

### **Burns**

The care for burns involves the following three basic steps:

1. **Stop** the Burning — Put out flames or remove the victim from the source of the burn.
2. **Cool** the Burn — Use large amounts of cool water to cool the burned area. Do not use ice or ice water other than on small superficial burns. Ice causes body heat loss. Use whatever resources are available—tub, shower, or garden hose, for example. You can apply soaked towels, sheets or other wet cloths to a burned face or other areas that cannot be immersed. Be sure to keep the cloths cool by adding more water.
3. **Cover** the Burn — Use dry, sterile dressings or a clean cloth. Loosely bandage them in place. Covering the burn helps keep out air and reduces pain and helps prevent infection. If the burn covers a large area of the body, cover it with clean, dry sheets or other cloth.



### **Chemical Burns**

1. Remove contaminated clothing.
2. Flush burned area with cool water for at least 5 minutes.
3. Treat as you would any major burn (see above).

If an eye has been burned:

1. Immediately flood face, inside of eyelid and eye with cool running water for at least 15 minutes. Turn head so water does not drain into uninjured eye. Lift eyelid away from eye so the inside of the lid can also be washed.
2. If eye has been burned by a dry chemical, lift any loose particles off the eye with the corner of a sterile pad or clean cloth.
3. Cover both eyes with dry sterile pads, clean cloths, or eye pads; bandage in place.
4. Sunburn
5. Treat as you would any major burn (see above).
6. Treat for shock if necessary (see **Shock**).

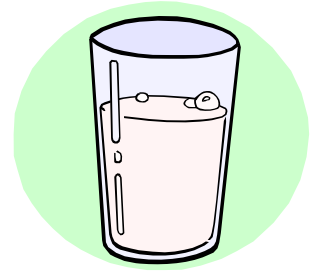
7. Cool victim as rapidly as possible by applying cool, damp cloths or immersing in cool, not cold water.
8. Give victim fluids to drink.
9. Get professional medical help immediately for severe cases.

## Heat Illness

Managers and Coaches must pay attention to weather conditions—especially in Florida. The danger zone is present whenever the temperature is above 90°F or the humidity is above 95%.

The following measures should be taken to reduce the risk of heat illness during competition or practice:

- Before the activity begins, drink 8 ounces of fluids.
- During the activity, drink at least 4 ounces of fluids every 20 minutes.
- After the activity, drink 16 ounces for every pound of weight lost.



### **Early Signs of Dehydration**

- Fatigue
- Loss of appetite
- Flushed skin
- Light-headedness
- Dark urine with strong odor

### **Severe Sign of Dehydration**

- Muscle Spasms
- Clumsiness
- Sunken eyes/dim vision

### **Delirium Dehydration**

Good nutrition is important for children. Sometimes, the most important nutrient children need is *water*—especially when they're physically active. When children are physically active, their muscles generate heat thereby increasing their body temperature. As their body temperature rises, their cooling mechanism—sweat—kicks in. When sweat evaporates, the body is cooled.

Unfortunately, children get hotter than adults during physical activity and their body's cooling mechanism is not as efficient as adults. If fluids aren't replaced, children can become *overheated*.

We usually think about dehydration in the summer months when hot temperatures shorten the time it takes for children to become overheated. Keeping children hydrated is just as important in the winter months, as well. Additional clothing worn in the colder weather makes it difficult for sweat to evaporate, so the body does not cool as quickly.

It does not matter if it's January or July, thirst is not an indicator of fluid needs. Therefore, *children must be encouraged to drink fluids even when they don't feel thirsty*. Managers and Coaches should schedule drink breaks every 15 to 30 minutes during practices on hot days, and should encourage players to drink between every inning.

During any activity, water is an excellent fluid to keep the body well hydrated—and it's also economical. Offering flavored fluids like sport drinks or fruit juice can help encourage children to drink. Sports drinks should contain between 6-8% carbohydrates (15 to 18 grams of carbohydrates per cup) or less. If the carbohydrate levels are higher, the sports drink should be diluted with water. Fruit juice should also be diluted (1 cup juice to 1 cup water). Beverages high in carbohydrates like undiluted fruit juice may cause stomach cramps, nausea and diarrhea when the child becomes active.

Caffeinated beverages (tea, coffee, colas) *should be avoided* because they are diuretics and can dehydrate the body further. Avoid carbonated drinks, which can cause gastrointestinal distress and may decrease fluid volume.

### **Heat Cramps**

**Symptoms** – May include: muscle tightening and spasm with intense pain, usually in the lower leg, but may be abdominal or rib cage. These muscle spasms usually do not respond to kneading or massage.

1. Instruct player to lie down in a cool, shaded area or an air-conditioned room.

### **Heat Exhaustion**

**Symptoms** - May include: fatigue; irritability; headache; faintness; weak, rapid pulse; shallow breathing; cold, clammy skin; profuse perspiration.

1. Instruct victim to lie down in a cool, shaded area or an air-conditioned room. Elevate feet.
2. Massage legs toward heart.
3. Only if victim is conscious, give cool water or electrolyte solution every 15 minutes.
4. Use caution when letting victim first sit up, even after feeling recovered.

### **Sunstroke (Heat Stroke)**

**Symptoms** - May include: extremely high body temperature (104°F or higher); hot, red, dry skin; no sweating; rapid pulse; confusion, disorientation, some agitation in milder cases, hallucinations, loss of consciousness and convulsions in severe cases.



1. Call **9-1-1** immediately; until emergency care arrives, it is important to lower the body temperature by:
  2. Moving the person to a cool place indoors or under a shady tree. Place the feet higher than the head.
  3. Remove the clothing and either wrap the person in a cold, wet sheet; sponge the person with towels or sheets that are soaked in cold water; or spray the person with cool water. Fan the person. If using an electric fan, use caution. Make sure your hands are dry when you plug the fan in and turn it on. Keep the person with wet items far enough away from the fan so as not to cause electric shock.
  4. Put ice packs or cold compresses to the neck, under the armpits and to the groin area.
  5. Immerse a child in cold water if he or she is unconscious.
  6. *Do not* give stimulating beverages (caffeine beverages), such as coffee, tea or soda.

### **Prescription Medication**

Do not, at any time, administer any kind of prescription medicine.



**This is the parent's responsibility** and the league does not want to be held liable, nor do you, in case the child has an adverse reaction to the medication.

## Asthma and Allergies



Many children suffer from asthma and/or allergies. Allergy symptoms can manifest themselves to look like the child has a cold or flu. Allergies are usually treated with prescription medication.

If a child is allergic to insect stings/bites or certain types of food, you must be informed about it on the player's *Medical Release* form. These allergic reactions can become life-threatening and the Manager must know which children on his team need to be watched.

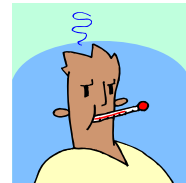
Likewise, a child with asthma needs to be watched because they can have a difficult time breathing during strenuous activity or even during cold weather.

If a child starts to have an asthma attack, have him stop playing immediately and calm him down till he/she is able to breathe normally. If the asthma attack persists, dial **9-1-1** and request emergency service.

## Colds and Flu

There is nothing you can do to help a child with a cold or flu except to recognize that the child is sick and should be at home recovering and not on the field passing his cold or flu on to all your other players.

**Prevention** is the solution here. Don't be afraid to tell parents to keep their child at home.



## Communicable Disease Procedures

While risk of one athlete infecting another with *HIV/AIDS* or the *Hepatitis B or C virus* during competition is close to non-existent, there is a remote risk other blood-borne infectious diseases can be transmitted. Procedures for guarding against transmission of infectious agents should include, but not be limited to the following:

- A bleeding player should be removed from competition as soon as possible.
- Bleeding must be stopped, the open wound covered, and the uniform changed if there is blood on it before the player may re-enter the game.
- Routinely use gloves to prevent mucous membrane exposure when in contact with blood or other body fluids.
- Immediately wash hands and other skin surface with antibacterial soap if contaminated with blood.
- Clean all blood contaminated surfaces and equipment with a 1:1 solution of Clorox Bleach (supplied in the concession stand). A 1:1 solution can be made by using a cap full of Clorox (2.5cc) and 8 ounces of water (250cc).

- Managers, Coaches, and volunteers with open wounds should refrain from all direct contact with others until the condition is resolved.
- Follow accepted guidelines in the immediate control of bleeding and disposal when handling bloody dressings, mouth guards and other articles containing body fluids.

### **Facts about AIDS and Hepatitis**

AIDS stand for acquired immune deficiency syndrome. It is caused by the human immunodeficiency virus (HIV). When the virus gets into the body, it damages the immune system, the body system that fights infection. Once the virus enters the body, it can grow quietly in the body for months or even years. People infected with HIV might not feel or appear sick. Eventually, the weakened immune system gives way to certain types of infections.

The virus cannot enter through the skin unless there is a cut or break in the skin. Even then, the possibility of infection is very low unless there is direct contact for a lengthy period of time.

Currently, it is believed that saliva is not capable of transmitting HIV. The likelihood of HIV transmission during a First-Aid situation is very low; but always use the proper procedures to protect you and the victim from disease transmission.

- If possible, wash your hands before and after giving care, even if you wear gloves.
- Avoid touching or being splashed by another person's body fluids, especially blood.
- Wear disposable gloves during treatment.

If you think you have put yourself at risk, get tested. A blood test will tell whether or not your body is producing antibodies in response to the virus. If you are not sure whether you should be tested, call your doctor, the public health department, or an AIDS hot line. In the meantime, don't participate in activities that put anyone else at risk.

Like AIDS, Hepatitis B and C are viruses. Even though there is a very small risk of infecting others by direct contact, one must take the appropriate safety measures, as outlined above, when treating open wounds. There is now a vaccination to prevent Hepatitis B. Managers are strongly recommended to see their doctor about this.

### **Attention Deficit Disorder (ADD)**

Attention-Deficit/Hyperactivity Disorder, or **ADD/ADHD**, is a neurobiological-based developmental disability estimated to affect between 3-5 percent of the school age population. This disorder is found present more often in boys than girls (3:1).

No one knows exactly what causes ADHD. Scientific evidence suggests that the disorder is genetically transmitted in many cases and results from a chemical imbalance or deficiency in certain neurotransmitters, which are chemicals that help the brain regulate behavior.

Unfortunately more and more children are being diagnosed with ADHD every year. There is a high probability that one or more of the children on a team will have ADHD. It is important to recognize the child's situation for safety reasons because not paying attention during a game or practice could lead to serious accidents involving the child and/or his teammates. It is equally as important to not call attention to the child's disability or to label the child in any way.



Hopefully, the parent of an ADHD child will alert the Manager to his/her condition. Treatment of ADHD usually involves medication. ***Do not, at any time, administer the medication***—even if the child asks you to. Make sure the parent is aware of how dangerous the game of baseball can be and suggest that the child take the medication (if he or she is taking medication) before he or she comes to the practice/game. A child on your team may, in fact, be ADHD, but has not been diagnosed as such. You should be aware of the symptoms of ADHD in order to provide the safest environment for that child and the other children around him.

### **What are the symptoms of ADD/ADHD?**

#### **Inattention** - Where the child:

- Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities;
- Often has difficulty sustaining attention in tasks or play activities;
- Often does not seem to listen when spoken to directly;
- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions);
- Often has difficulty organizing tasks and activities;
- Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework);
- Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools);
- Often easily distracted by extraneous stimuli;
- Often forgetful in daily activities.

#### **Hyperactivity** - Where the child:

- Often fidgets with hands or feet or squirms in seat;
- Often leaves seat in classroom or in other situations in which remaining seated is expected;
- Often runs about or climbs excessively in situation in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings or restlessness);
- Often has difficulty playing or engaging in leisure activities quietly;
- Often "on the go" or often act as if "driven by a motor;"
- Often talks excessively.

#### **Impulsivity** - Where the child:

- Often blurts out answers before questions have been completed;
- Often has difficulty awaiting turn;
- Often interrupts or intrudes on others (e.g., butts into conversations or games).

#### **Emotional Instability** - Where the child:

- Often has angry outbursts;
- Is a social loner;
- Blames others for problems;
- Fights with others quickly;

- Is very sensitive to criticism.

Most children with ADHD experience significant problems socializing with peers and cooperating with authority figures. This is because when children have difficulty maintaining attention during an interaction with an adult, they may miss important parts of the conversation. This can result in the child not being able to follow directions and so called “memory problems” due to not listening in the first place.

When giving directions to ADHD children it is important to have them repeat the directions to make sure they have correctly received them. For younger ADHD children, the directions should consist of only one or two step instructions. For older children, more complicated directions should be stated in writing.

Children with ADHD often miss important aspects of social interaction with their peers. When this happens, they have a difficult time “fitting in.” They need to focus in on how other children are playing with each other and then attempt to behave similarly. ADHD children often enter a group play situation like the proverbial “bull in the china closet” and upset the play session.

There is no way to know for sure that a child has ADHD. There is not simple test, such as a blood test or urinalysis. An accurate diagnosis requires an assessment conducted by a well-trained professional (usually a developmental pediatrician, child psychologist, child psychiatrist, or pediatric neurologist) who knows a lot about ADHD and all other disorders that can have symptoms similar to those found in ADHD.

## Injury Reporting and Monitoring

Managers and Coaches can find the *ASAP Incident/Injury/Tracking Report* and *AIG Insurance Claim Forms* in **Chapter 6 - Appendix**. Any injury reports must be turned to the Safety Officer’s mailbox at the complex within 24-48 hours of the incident.

## Altercations

Undoubtedly, in youth sports there are going to be conflicts. To prevent small conflicts from escalating to disputes or violent actions, try using *Little League’s 7 Steps of Conflict Resolution*. Remember—you don’t have control over other people’s actions, but you do have control of your own.

### Little League Tips for Conflict Resolution

**Step 1: Speak to the person privately.** No one likes to be belittled and berated publicly. Choose an appropriate time and place to have a conversation about the problem.

**Step 2: Listen Actively.** Active listening involves focusing completely on what the person with the conflict says.

**Step 3: Reverse Roles.** After the person tells you their concern, respond back with “I understand what you’re saying is...” then restate their concern. If you don’t quite understand their concern, ask them to clarify it.

**Step 4: Expressing Feelings.** The person with the concern also needs to give you a chance to express your feelings on the conflict at hand. Use the phrase, "I feel..." when expressing your feelings on the matter.

**Step 5: Solving the Problem.** Suggest ways that you can solve the conflict.

**Step 6: Select a WIN/WIN solution.** Look at the suggestion you'd made in Step 4 and choose a solution that benefits both parties involved.

**Step 7: Agree on a Follow-Up.** If the concern is not resolved or comes up again, offer to revisit it and try to work out another solution.

