Standing Orders for [insert school name here]

JULY 1, XXXX [YEAR] – JUNE 30, XXXX [YEAR]JULY 1, [YEAR] – JUNE 30, [YEAR]

**-Medical Emergencies-**

***Medical emergencies are classified as situations which are life-threatening to the athlete. (ie: loss of consciousness, absence of breathing, absence of pulse, and severe bleeding)***

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# General Procedures

Responsibilities**:**

1. Administration of first aid to injured athletes with appropriate referrals.
2. Proficiency in CPR (professional rescuer), transport of injured athletes and reactions to emergency situations.
3. Application of injury prevention devices.
4. Treatment & rehabilitation of injuries, as instructed by a physician.
5. Communication of injuries and a cooperative relationship with a physician.

Guidelines**:**

1. Never discuss an injury with anyone other than a physician or a professional consultant.
2. Abide by medical privacy laws but will discuss injuries with coaches as necessary for participation.
3. Never discuss injuries directly with media unless approved by the athlete, the school, the parents, and the coaching staff.

Duties**:**

1. Coverage of high-risk sports as allocated by [insert school name here] Athletics and hourly allotment.
2. Hold office/treatment hours at the Athletic Training Room located in [insert location of ATR here]
3. Dress neatly. Work conduct and appearance represents [insert school name here] as well as our profession. Look and act professionally.
4. Maintain up to date injury-reports, treatment logs, and treatment planners.
5. Learn all emergency policies for events at home & off campus “home” events.
6. Follow all policies & procedures.
7. Be prompt or be early.
8. Complete inventory as assigned.
9. Stock tape & supply areas after usage.
10. Check kit daily to ensure it is adequately stocked.

# Universal Precautions

1. The athletic trainer (AT) will utilize Occupational Safety Manual of procedures and policies for compliance with OSHA Blood Borne Pathogen.
2. The AT participates in a blood borne pathogens standard training program upon employment and annually thereafter.
3. Accurate medical and training recordkeeping by OSHA regulations is kept on each person in a confidential manner at administration.
4. Hepatitis B Vaccine and vaccination series are available to the AT.
5. The AT routinely uses appropriate barrier precautions to prevent skin and mucous membrane exposure when in contact with blood and other body fluids.
	1. Gloves are worn:
		1. When touching blood and body fluids, mucous membranes or non-intact skin of all patients.
		2. While handling items or surfaces soiled with blood or body fluids.
	2. Gloves are changed after contact with each patient.
6. Hands and skin surfaces are washed immediately and thoroughly if contaminated with blood or other body fluids. Hands are washed immediately after gloves are removed.
7. The AT should take precautions to prevent injuries caused by needles, scalpels and other sharp instruments or devices used during procedures; when cleaning used instruments; and when handling sharp instruments after procedures.
8. A step-top lid bio-medical waste container will be located in the Athletic Training Room.
	1. These are replaced by a medical disposal company.
9. Personal protective equipment will be stocked in the Athletic Training Room.
	1. This includes gloves, bio-waste containers, etc.
10. The Athletic Training Room will be equipped with OSHA regulated biohazard pails and labels.
11. The Athletic Training Room should be equipped with a spill kit on-site.

# Abdominal Trauma

Exam

1. General appearance
2. Vital Signs
	1. Temp
	2. Pulse
	3. Respiration
	4. BP
	5. Skin color
	6. Pupils
	7. State of consciousness
3. Inspect abdomen
	1. Areas of discomfort
	2. Note the appearance of color/stretch marks/bruising/redness/rash
	3. Are four quadrants all equal size?
	4. Masses or pulsations
4. Auscultation – listen to bowel sounds with stethoscope (present/not present or normal/abnormal)
5. Percussion of abdomen (discomfort with percussion?)
6. Palpation
	1. Note – resistance/rigidity/masses/rebound
	2. If more tender than usual – point tenderness rebound tenderness

Care

1. Supine
2. Knees slightly flexed and supported
	1. If athlete is going to be sick, they should be placed in the recovery position on their left side.
3. Loosen clothes
4. Vitals – TAKE OFTEN!
5. Note position of athlete
6. If athlete vomits, check vomit for blood, food, bile, mucous, etc.
7. NEVER GIVE FOOD OR DRINK!
8. If signs/symptoms present - transport
9. If no signs/symptoms - monitor and repeat history and evaluation the following day.
10. Be sure to ask about changes, hematuria, discomforts, and abnormalities post-injury.

# Anaphylaxis (Allergic Reactions)

*Signs and Symptoms of an allergic reaction may include:*

**MOUTH - itching, swelling of lips and/or tongue**

**THROAT\* - itching, tightness/closure, hoarseness**

**SKIN - itching, hives, redness, swelling**

**GUT - vomiting, diarrhea, cramps**

**LUNG\* - shortness of breath, cough, wheeze**

**HEART\* - weak pulse, dizziness, passing out**

***Only a few symptoms may be present. Severity of symptoms can change quickly.***

***\*Some symptoms can be life-threatening. ACT FAST!***

*\*the above symptoms are directly from the American Academy of Allergy, Asthma, and Immunology*

Care

1. Students with diagnosed allergies that require an epi pen must carry their epi pen with them at all practices, games, etc. It is the coach’s responsibility to ensure the epi-pen is present with them at all times.
2. Trained personnel should administer epi-pen after recognition of signs/symptoms
	1. AT may use epi-pen if necessary in an emergency situation as prescribed by a team physician
	2. Use of an epi pen
		1. In persons over 100 pounds
		2. Use with extreme caution in patients with heart disease
		3. Do not use in persons on cardiac, thyroid, or psychotropic drugs
		4. Use with caution in diabetics, elderly, or pregnant women
3. Immediately activate EMS
4. Monitor airway, breathing, circulation, loss of consciousness, etc.
5. Lay the athlete in a supine position with legs elevated to decrease risk of shock
6. Encourage athlete to minimize movement until EMS arrives
7. If necessary, perform CPR/AED
8. Send Epi pen with athlete in the ambulance

\*\* If stinger from bee is present, first responder should remove it as quickly as possible.

Return to play

1. Athletes who experience anaphylaxis must be cleared by their primary care physician (PCP) or team physician before returning to activity.
2. Individualized and gradual return to play will be initiated after physician’s clearance.

# Asthma

*Signs and symptoms of an asthma attack may include:*

1. *Difficulty speaking*
2. *Chest pain*
3. *Wheezing*
4. *Shortness of breath*
5. *Coughing*
6. *Drowsiness*
7. *Confusion*
8. *Sweating*
9. *Altered mental status decrease/loss of consciousness – if severe*

Care

1. Each athlete will be responsible for carrying their rescue inhaler with them to practice, games, etc.
	1. The coach is responsible for ensuring the athlete has their rescue inhaler with her/his at all times.
2. With onset of symptoms:
	1. Stop activity and obtain rescue inhaler
	2. Calm athlete
	3. Instruct athlete on proper breathing techniques
	4. Administer dosage of inhaler (this may be the AT, coach or self-administered)
3. If symptoms do not improve or start to worsen, call EMS
4. Monitor vitals until EMS arrives
5. Be prepared to perform CPR and use AED if necessary

# Cardiac Arrest

\*\* a collapsed athlete who is unresponsive must be treated as having cardiac arrest, until another diagnosis is determined or until the athlete becomes responsive again\*\*

*Signs and Symptoms of Sudden Cardiac Arrest include…*

1. *Sudden collapse*
2. *No pulse*
3. *No breathing*
4. *Loss of consciousness*

Care

1. Call EMS and activate EAP
2. Transport athlete to safe scene if necessary
3. Immediately retrieve AED
	1. AED should be on scene for any athletic activity
	2. AED will be with AT for any events covered
4. Immediately begin CPR/AED
5. Continue CPR/AED and monitor vitals until EMS arrives

# Cervical Spine Injury

The presence of any or all of the following warrant the activation of the spine injury protocol:

* Unconsciousness or altered level of consciousness
* Abnormal bilateral neurological findings or complaints
* Significant cervical spine pain with or without palpation
* Obvious spine deformity

Immediate Care

*\*AT on field must possess facemask removal device (i.e. electric screw driver & other tools)*

1. Activate EAP and call EMS
2. Stabilize head and neck.
3. Determine airway, breathing, circulation
4. If athlete is **NOT BREATHING** - access airway by removing facemask and begin CPR
5. Neutral alignment:
	* 1. If head is not in neutral alignment, return head to neutral alignment (anatomical position) to allow for better airway alignment
		2. The presence or development of any of the following while moving the head represents a contraindication for realigning:
			+ 1. Movement causes increased pain, neurological symptoms, muscle spasm
				2. Results in airway compromise
				3. It is physically difficult to reposition the spine
				4. Resistance is encountered during the attempt
				5. Patient experiences apprehension
6. If athlete has **NO PULSE** - access chest and begin CPR and retrieve AED
7. Determine level of consciousness
	1. Verbal stimuli (i.e. calling athlete’s name out loud)
	2. If no response to verbal, try painful arousal
		1. Pinch the skin
		2. Firmly rub knuckle into athlete’s sternum
	3. if **COMPLETELY UNRESPONSIVE**
		1. Prepare to apply spinal motion restriction techniques and transport
	4. if **ALERT and RESPONSIVE**
		1. Brush over extremities to test for sensations
		2. Ask athlete to move fingers and toes on each side
		3. Lack of sensation or inability to move - immobilize and transport
8. Determine long term memory and short-term memory
9. **ANY SIGN OF DEFICIT** is reason to keep athlete immobilized and await arrival of EMS
	1. Monitor vitals frequently
10. If athlete demonstrates **NO NEUROLOGICAL DEFICITS**:
	1. Palpate cervical spine and upper trap region
	2. If all tests are negative to this point, supine isometric RROM can be initiated
	3. If s/sxs do not increase or worsen with supine isometric testing progress to AROM
	4. If s/sxs do not increase or worsen with supine AROM, then ask athlete if they are comfortable sitting up
	5. If s/sxs do not increase or worsen and athlete is willing to sit up help athlete to a seated position, then assess AROM again
	6. If s/sxs do not increase or worsen with seated AROM, athlete my stand with assistance and a further secondary evaluation may take place on the sideline
	7. *If at any time during the evaluation there is any concern or objective finding that demonstrates any possibility of cervical spine injury the athlete must be immobilized and transported immediately.*

Return to play

1. PHYSICIAN’S CLEARANCE
2. Minimal or no neck tenderness
3. Full active range of motion
4. Normal neurology exam
	1. Normal, symmetrical neck strength
	2. Normal, symmetrical limb strength
	3. Normal, symmetrical reflex and sensations
5. No tingling, burning, weakness, or numbness in any limb

# Concussions

\*\* Any coach who suspects an athlete may have a concussion (see symptoms below) must remove that athlete from play until assessed and cleared by an appropriate health care professional such as an AT\*, physician, physician assistant, APRN in accordance with CT Concussion Law \*\*

|  |  |
| --- | --- |
| **Features of a Concussion****(observed by someone else)** | **Symptoms of a Concussion****(complaints from athlete)** |
| - Vacant stare − Delayed verbal and motor responses− Confusion and inability to focus attention − Disorientation − Slurred or incoherent speech− Gross observable deficits in coordination − Emotions out of proportion to circumstances − Memory deficits− Loss of consciousness | Early (minutes and hours) − Headache − Dizziness or vertigo − Lack of awareness of surroundings − Nausea or vomiting Late (days to weeks): − Persistent low grade headache − Light-headedness − Poor attention and concentration − Memory dysfunction − Easy fatigability − Irritability and low frustration tolerance − Intolerance of bright lights or difficulty focusing vision − Intolerance of loud noises, sometimes ringing in the ears − Anxiety and/or depression |
| \*above signs and symptoms are not all inclusive and other signs or symptoms of a concussion may be present. |

\*\*Features/symptoms were supplied by the American Academy of Neurology

Red Flags:

* Any deterioration of mental/neurological status increase in severity of symptoms, vomiting, prolonged loss of consciousness, reports of numbness/tingling, the athlete must be referred to the emergency room immediately.

Baseline Testing

1. [insert baseline testing requirements for school here]

On-field Management

1. Determine level of consciousness
2. Assess ABC’s
3. Check for neck or spinal injury
	1. If asymptomatic, may walk off field
	2. Possible neck/spine, immediately IMMOBILIZE and activate EMS
4. Loss of Consciousness: emergency transport
5. No matter how long symptoms last, any athlete who shows any signs of a concussion or is suspected of having a concussion **must be removed from play for that day and is not allowed to return.**
	1. *When in doubt, sit them out!*

Off-field Management

1. Recheck vitals
2. SCAT 5
3. Vision
	1. Any reports of photophobia, diplopia, or other trouble with vision
4. Neurologic tests (dermatomes/myotomes/cranial nerves, pupils – Pupils Equal, Round, Reactive to Light, Accommodation (PERRLA)
5. Re-check athlete continuously post-injury to monitor signs and symptoms
6. Inform both athlete and parent/guardian of signs and symptoms to monitor for at home both verbally and in written form.
	1. [insert school specific notification protocols here for concussion notification]

Follow-Up

* + - 1. Reassess 24 hours post injury when possible with ATC schedule.
			2. Daily Monitoring sheet will be performed with nurse.
			3. Refer to physician if symptoms persist or athlete does not have improvement in symptoms over a period of [tbd with physician]
			4. Once the athlete is 100% symptom free for 24 hours they will be allowed to begin return to play protocols.

Return to play

1. The AT and/or a physician (with proper documentation) must clear the athlete [revise based on decision with team physician].
	1. Athletes may see their own Primary Care Physician or Team Physician.
		1. Athletes will be recommended to see a sports medicine, neurologist or other physician who is certified in concussion management.
	2. If athlete is cleared by their PCP and [insert school name here] AT suspects athlete is not ready to be cleared, they can ask parents to consider seeing the Team Physician for a second opinion.
	3. Should AT feel it is unsafe for athlete to play, the AT will consult with the team physician and together, the AT and team physician have the ultimate decision on return to play status.
2. Prior history of concussion should be considered when making a return to play decision
	1. # of concussions in season/lifetime
	2. Severity of concussions
3. The athlete must be symptom free before being cleared to return to play
4. Return to learn
	1. Academic accommodations (with appropriate documentation) may be prescribed. The AT will help manage communication between the school, school nurse (when applicable) parent(s)/guardian(s), and physician(s).
5. Student-athletes should successfully return to full academic participation (when school is in session), using a multi-step return to learn protocol, prior to student athletes return to play for sport.
	1. Simultaneously, student athletes may engage in activities of sub-symptom threshold, such as vestibular, vision and exertional therapy (ex. sub-maximum aerobic strength training activity) in their recovery from sport related concussion as directed by their healthcare provider. However, this is part of the treatment protocol and is not considered return to play for sport.
6. Once clearance has been granted by the AT and/or a physician, the athlete will progress through a gradual return to play before being allowed to return to full activity.
	1. An example of this RTP is as follows:
		1. Day 1- Light jog at a relatively slow pace for 20 minutes
		2. Day 2- Run for 20 minutes
		3. Day 3 – Moderate Activity; practice without contact; not 100% of practice
		4. Day 4- Full intensity; non-contact
		5. Day 5 – Full activity, full contact
	2. If signs/symptoms reoccur during any of the testing, the athlete must cease activity for 24 hours. The athlete will resume return to play protocol as tolerated.
	3. The progressive RTP guidelines may be altered depending on the situation and team physician approval.

# Diabetes

*Signs and Symptoms include:*

1. *Frequent urination*
2. *Thirst*
3. *Hunger*
4. *Weight loss*
5. *Visual disturbances*
6. *Fatigue*
7. *Ketosis*
8. *Tachycardia*
9. *Sweating*
10. *Palpitations*
11. *Weakness*

Care

1. Each athlete with diabetes is responsible for having all appropriate documentation and equipment to manage symptoms at all practices and games. (blood glucose meter, glucose tablets, glucagon injection, and/or insulin pump)
2. If athlete presents signs of hypoglycemia (blood glucose levels <70mg/dL), the AT can administer glucose tablets.
	1. Signs and symptoms of hypoglycemia may include:
		1. Confusion
		2. Unusual behaviors
		3. Visual disturbances (double vision or blurred vision)
		4. Heart palpitations
		5. Tremors
		6. Anxiety
		7. Sweating
		8. Hunger
		9. Seizures (uncommon)
		10. Loss of consciousness (uncommon)
3. Monitor vitals and signs/symptoms
	1. If conditions worsen activate EAP and call EMS.

4. Athlete will NOT be permitted to participate if pre-exercise blood glucose is > 250mg/dL.

Return to play

1. Ability to resume sport and exercise can occur within weeks of starting insulin treatment.
2. Diabetes management is determined by the athlete, parents/guardians, AT, nurse, team physician, coach, and school administrators together.

# Eating Disorders

*AT must recognize and refer when presented an athlete with an eating disorder*

 *(ie anorexia and bulimia)*

*Signs and symptoms of eating disorders may include:*

|  |  |
| --- | --- |
| *Anorexia Nervosa* | *Bulimia Nervosa* |
| *-dieting despite being thin**-obsession with calories**-pretending to eat**-lying about eating**-constantly thinking about food**-strange or secretive eating rituals (refusing to eat around others or in public places)* | *-lack of control over eating**-secrecy surrounding eating**-eating unusually large amounts of food**-going to the bathroom after meals**-use of laxatives, diuretics**-excessive exercising* *-not underweight**-discolored teeth (puking)**-calluses or scars on knuckles/hands* |

*\*\*These signs and symptoms were retrieved from helpguide.com*

Therapeutic Intervention:

1. If a coach, athlete, or friend of an athlete with a suspected eating disorder approaches the AT, AT must act within scope of practice.
2. AT must facilitate timely referrals.
3. Eating disorder diagnosis and treatment can only be managed by physicians and psychotherapists specializing in eating disorders.
4. AT may enforce limitations of physical workouts as stated by care-giver and intervene when becoming potentially dangerous.
5. Written contracts with the athlete may be necessary for compliance to continue her/his modified sport involvement.
6. Parent/guardian support should be obtained before implementing any regulations.

# Environmental Injury Care

*Signs and symptoms for heat illness:*

|  |  |  |
| --- | --- | --- |
| **Heat Cramps** | **Heat Exhaustion** | **Heat Stroke** |
| * Fatigue
* Dehydration
* Muscle cramps/pain
* Hot and wet or dry skin
* Core body temp <40C
 | * Fatigue
* Dehydration
* Hot and wet or dry skin
* Cool, clammy skin
* Pale skin
* Dizziness
* Headache
* Light-headedness
* Staggering
* Syncope
* Core body temp <40C
* Chills
* Hyperventilation
* Vomiting
 | * Fatigue
* Dehydration
* Hot and wet or dry skin
* Dizziness
* Drowsiness
* Headache
* Staggering
* Syncope
* Personality changes\*\*
* Core body temp >40C
* Diarrhea
* Hypotension
* Nausea/vomiting
* Seizures
* CNS dysfunction
* Tachycardia (100-120 bpm)
 |

\*CNS dysfunction includes but is not limited to altered levels of consciousness, coma, confusion, disorientation, collapse, etc.

\*\*Personality changes include but are not limited to hysteria, irrational behaviors, combativeness, aggressiveness, irritability, apathy, decreased mental acuity, etc.

## Heat Cramps

1. Remove from contest
2. Administer fluids (if necessary)
3. Stretch involved muscle
4. Rest if necessary

## Heat Exhaustion

1. Remove athlete to cool area
2. Remove clothing and equipment
3. Lower body temperature by ice bags/ice towels on neck, arm pit, groin and other parts of body.
4. Give fluids to athlete, if necessary
5. If not a rapid improvement, activate EAP and call EMS

## Exertional Heat Stroke (EHS)

1. Call 911 immediately - **THIS IS A TRUE MEDICAL EMERGENCY**
2. Remove the athlete from the environment. Move to shaded or indoor cooled area and obtain core temperature (rectally).
	* 1. Temperature over 105°F with CNS dysfunction constitutes for EHS
3. Cold water immersion is the gold standard for treating an athlete with exertional heat stroke. Patients suffering from EHS should be immersed in a cold water immersion tub immediately
	1. Cold water immersion tubs should be set up for all warm-weather practices and competitions
		1. Set up includes: filled with water, 2 chests of ice beside the tub
	2. Cold water immersion should continue until core body temperature (measured by rectal temperature) reaches 102°F
		1. Patients should NOT be transported to the hospital until cooling has ceased
4. Following reaching 102°F, patients should be transported to the hospital for further follow up

## Hypothermia

1. Remove from environment
2. Place in warm environment
3. Give warm fluids if conscious
4. If improvement does not occur activate EAP and call EMS

## Lightning

Precautions for a storm:

1. If lightning and/or thunder are present notify officials to stop contest.
	1. *“When Thunder Roars Go Indoors”*
2. Instruct coach to escort team to bus, school, or nearest building
	1. If shelter is not available assume the safe position:
		1. Crouch down, feet together, weight on the balls of your feet
		2. Cover ears
		3. Do NOT lay down
3. Notify fans via announcement to take cover inside vehicles
4. Contest will be suspended a minimum of 30 minutes after the last lightning/thunder.

If lightning strike occurs:

Signs/symptoms: hair standing on end, sound of sizzling

1. DO NOT RUSH TO THE SITE! Make sure it is safe for you to go help.
2. Activate EAP and call EMS immediately.
3. Treatment
	1. Injuries to be prepared for
		1. Burns
		2. Cardiac arrest
		3. Head and neck injury
		4. Respiratory issues
		5. Loss of consciousness
		6. Vascular injury
	2. Administer CPR and AED, as necessary
4. You may encounter anywhere from one victim to a triage situation:
	1. Victims who are breathing and have a pulse, regardless of the state of consciousness, are generally going to do well.
	2. Victims without a pulse and respiration are the ones on whom the rescuer will have the biggest impact.

# Exertional Sickling

*Signs and Symptoms:*

1. *Can occur early, in any season, in any temperature,*
2. *Mild pain, with weak muscles (not like a cramping)*
3. *Slump to a stop (from weakness, not locked up muscles)*
4. *Athlete lies fairly still and complains little*
5. *Muscles look and feel normal*
6. *Athlete can usually still talk or respond*
7. *Signs/symptoms may deteriorate rapidly and may become unresponsive*

Care

1. Remove athlete from activity at first sign of any symptoms.
	1. Universal precautions will be utilized.
2. Assess vital signs.
3. Watch for shock, and treat if necessary.
4. Watch for decreased levels of arousal and responsiveness, or tachycardia that develops into bradycardia.
5. Provide supplemental oxygen (if available through EMS).
6. Cool athlete if necessary.
7. If condition does not rapidly improve, activate EAP and call EMS.
8. Attach AED and start CPR if necessary.

Return to Play

* Athlete must be cleared by a physician to return to play.
* A gradual progression back into sport activity must be implemented by the AT once the athlete is cleared to return.

# Muscular Trauma

The AT may initiate injury prevention programs to prevent musculoskeletal injuries.

For athletes suffering from a muscular trauma, the following assessment and management protocols should be in place:

1. Remove from activity
2. Evaluate and assess injury
3. Apply ice and compression
4. Elevate injury
5. If minor
	1. Minor injuries are any injury in which patient pain levels are tolerable, patient is able to put weight on limb, no deformity is present, or at the AT’s discretion.
	2. Provide initial treatment as necessary.
	3. Reassess within 24 hours, with nurse, coach and parent notification.
6. If Major
	1. Major injuries are any injury in which the patient’s pain is intolerable, patient is unable to put weight on limb, a deformity or rupture is present, or at the AT’s discretion.
	2. Immobilize and send to Emergency Room.

# Sprains/Strains/Fractures

1. Check history
	1. “pop” or “snap” ?
	2. Is the injury acute or chronic?
2. Deformity PRESENT…
	1. Evaluate
	2. Immobilize above and below joint
	3. Non-weight bearing
	4. Refer to hospital for follow-up or call 911
	5. Apply ice and elevate, if possible
	6. Check distal pulse and capillary refill
	7. Care for bleeding
	8. Treat for shock, if necessary
3. NO DEFORMITY PRESENT…
	1. History
	2. Observations
	3. Palpation
	4. AROM/PROM/RROM
	5. Special Tests
	6. Check weight bearing status
	7. Immobilize, if necessary
	8. R.I.C.E.
	9. Reexamine in 24 hours
	10. Refer to MD, if necessary…
		1. Signs and symptoms do not improve
		2. Prolonged time loss

Return to play

1. Minimal pain in affected area
2. FROM
3. Full strength and sensation
4. Normal gait (one legged hop)
5. Perform functional and sport specific tests at appropriate level

Orthopedic Treatment

The AT for [school name] may initiate care for injuries sustained by their student-athletes. This care may include all of the following:

* + 1. Taping or bracing
		2. Compression
		3. Elevation
		4. Electrical stimulation
		5. Rehabilitative exercise
		6. Hot packs
		7. Joint mobilizations
		8. Massage

# Wounds

Abrasions:

1. Check for foreign bodies
2. Cleanse with saline solution, hydrogen peroxide, or wound wash spray, for copius irrigation
3. Apply antibiotic ointment and dressing
4. Instruct athlete in care and precautions/signs and symptoms of infection

Lacerations:

1. MINOR
	1. Cleanse with antiseptic
	2. Dress as needed
2. MAJOR
	1. Control bleeding with direct pressure and bandage
	2. Steri-Strip the wound if applicable
	3. Apply dressing and wrap with gauze
	4. Send to emergency room – notify nurse and parent
	5. If bleeding is under control and can be dressed, but needs stitches, refer to MD within six hours

Splinters:

1. Sterilize removal instrument
2. Disinfect area with betadine or hydrogen peroxide
3. Using gentle motions, ease debris out of dermis
4. Cleanse thoroughly and dress with sterile dressing

Blisters:

1. Intact
	1. Pad with doughnut
	2. Apply protective dressing
2. Open
	1. Apply protective dressing

# Formulary for OTC Preparations

1. Alcohol May be used topically for skin care.
2. Triple Antibiotic Ointment May be used topically for minor abrasions and lacerations.
3. Caladryl May be used topically for rash and insect bites.
4. Contact solution May be used for the rinsing and storing of contacts.
5. Eye irrigating solution May be used to flush eyes.
6. First Aid cream May be used topically for minor burns and skin irritations.
7. Glucose gel or tablets May be given as treatment for low blood sugar.
8. Hydrogen peroxide May be used topically to clean infected wounds.

May be used at ½ strength as a mouth rinse.

1. Petroleum Jelly May be used for chapped lips or dry skin.
2. Provodine Iodine May be used topically to clean wounds.
3. Sting Relieving Wipes May be used topically for insect bites/stings.
4. Tape remover May be used in the removal of tape adhesive.
5. Tuff-skin May be used as a tape adhesive
6. Skin Lube May be used for comfort with tape jobs.
7. Saline Spray May be used topically to clean infected wounds.

\*be sure to notify infirmary and school physician regarding any skin diseases.

# Team Physician (or as specified by state regulation)

The team physician (or as specified by state regulation) for [insert school here] is: [insert name here]

Contact information: [insert address, phone, email, etc.]

The AT for [insert school name here] will communicate and update these standing orders with said physician yearly by [insert date].

Further, the AT for [insert school name here] is able to communicate with [insert name here] by [call/text/email] with any questions on athlete injuries or illnesses.

# Standing Orders Approval

The preceding section on standing orders was developed to reflect the standard of care that the [insert school name here] athletic training staff at the [insert school name here] must follow. The standing orders were developed in accordance with Connecticut State Law Chapter 375a\* P.A.00-226.

The following standing orders have been established for the management of athletic injuries. These procedures are standards of care authorized for the [insert school name] Athletic Training Staff under the consent and direction of the school’s Team Physician.

These medical directives have been approved by:

Supervising Physician:

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Athletic Trainer:

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_