



EMERGENCY ACTION PLAN

2025/2026 SEASON

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OVERVIEW

An emergency action plan (EAP) is a written document that states what is to be done in an emergency situation with the purpose of eliminating mistakes or oversight when time is a critical factor. All Comsewogue Youth Athletic Association coaches, administrators and team personnel are required to familiarize themselves with this plan at the beginning of each athletic season to understand the designated roles and responsibilities as well as the outlined protocols in case of any emergency. Any questions should be asked to the CYAA Board Members in the absence of a Certified Medical Professional.

A situation is considered an emergency if Emergency Medical Services (EMS) is needed to give further medical attention and/or transport a patient to the hospital. An emergency may arise at any time during an athletic event, and can involve an athlete, a coach, an official, a spectator, or even an administrator. As emergencies may occur at any time during any activity, the youth league has a responsibility to be properly prepared. Expedient action must be taken in order to provide quality care during emergencies and/or life-threatening situations. It is important that in these situations' coordination, established through detailed discussions, between the coaches and administrators be effective in order for emergency situations to be managed appropriately. Therefore, the development and implications of an emergency action plan will ensure that the best care is provided.

Situations when 911 should be called **are:**

- An athlete is not breathing
- An athlete has lost consciousness
- It is suspected that an athlete may have a neck or back injury
- An athlete has an obvious or open fracture (bone has punctured through the skin)
- Severe heat exhaustion or suspected heat stroke
- Severe bleeding that cannot be stopped

4 Components of the Emergency Plan

1. Emergency Personnel
2. Emergency Communication
3. Emergency Equipment
4. Venue Specific Action Plan & Directions

The Emergency Action Plan also includes the following action plans:

Sudden Cardiac Arrest, Head & Neck Injury, Lightning,
Heat Illness, Asthma

EMERGENCY PERSONNEL

Type and degree of medical coverage for an athletic event may vary widely based on factors such as sport, activity, setting and type of training or competition. Most commonly, the first responder in an emergency situation is a Police Officer or Emergency Medical Technician.

In some instances, the first responder may be a coach or league personnel. Coaches are required to be trained and maintain certification in First Aid, CPR/AED, and Concussion recognition. Training must be completed prior to supervision of athletes. All new athletic personnel must complete the training unless they provide proof of current certifications.

The development of an emergency plan cannot be complete without the formation of an emergency team. The emergency team members may consist of several healthcare providers including physicians, emergency medical technicians, and certified athletic trainers. Administrators and coaches also have responsibilities in an emergency. Roles of these individuals within the emergency team may vary depending on various factors such as the number of team members present, the athletic venue itself, or the preference of the Certified Athletic Trainer.

Chain of Command:

Police Officer

Emergency Medical Technicians

Administrator

Head Coach

Assistant Coach

The Highest person in the chain of command who is present at a scene will be the designated person in charge, or leader. That person is responsible for deciding whether or not to call 911, instructing others how they may be of help and will be the person who stays with the patient until EMS arrives.

ROLES OF EMERGENCY PERSONNEL

The following individuals may be directly involved with an emergency situation involving an athlete, coach, spectator, administrator, or official and therefore must be competent in the responsibilities of the first responder.

Comsewogue Head Coaches:

Responsibilities:

- Act as First Responder when EMT is not present
- If EMT/ Director is not readily available, call 911.
- Assign a bystander (if present) to notify Director that EAP has been activated.
- Assist in an emergency situation by keeping the players and surrounding bystanders a significant distance from the scene of the injury.
- Assist EMT and Director as instructed.

Assistant Coaches/Team Parents:

Responsibilities:

- Keep players, parents, and spectators a significant distance away from the scene of an injury.
- Assist the EMT and Coaching staff as instructed.

ROLE OF THE FIRST RESPONDER

1. Scene Safety & Immediate Care:

Establishing safety of the scene and immediate care of the athlete is paramount. The most qualified individual on the scene should provide acute care in an emergency situation. In most instances, the Head Coach will assume this role.

2. Calling Local Fire Department:

EAP activation may be necessary in situations where emergency transportation is not already present at the sporting event. This should be done as soon as the situation is deemed an emergency or a life-threatening event. Time is the most critical factor under emergency conditions.

Activating the EAP system may be done by anyone on the emergency team, however, the person chosen for this duty should be someone who is calm under pressure and who communicates well over the phone. This person should also be familiar with the location and address of the sporting event. Typically, the League Designated Field Representative is the best choice to fulfill this role.

3. Equipment Retrieval:

Retrieval of additional medical equipment may be done by anyone on the emergency team who is familiar with the types and location of the specific equipment needed. Coaches and Assistant Coaches are good choices for this role.

4. Directing EMS:

One member of the emergency team should be responsible for meeting EMS as they arrive. Depending on ease of access, this person should have keys to locked gates/doors that may slow the arrival of medical personnel.

League Director, or Coach may be appropriate for this role.

EMERGENCY ACTION STEPS

(Check-Call-Care)

The following is an outline of the established protocol to follow in order to effectively & efficiently manage a medical emergency situation.

A. Check: Check Airway, Breathing, and Circulation, level of consciousness, and for severe bleeding.

1. EMT (if present) will make the initial evaluation.
2. If the first responder is not an EMT, or Athletic Trainer, evaluate and determine the severity of the situation.

B. Call: Activate Emergency Medical Services (EMS)

1. Activate EMS by dialing 911 or have a bystander call.
 - a. Assign another bystander (if present) to notify director that EMS has been activated.
 - b. Have bystander retrieve an AED.
2. Give **Local Fire Department/Police Department** proper and thorough information.

State your name

Age & gender of injured athlete

Condition of athlete (breathing, conscious, etc.)

Location of injured athlete

Number of athletes

Treatment given (CPR, rescue breathing, AED, etc.)

Any other information requested

3. League Director/Game Administrator will direct EMS to location once on campus.

C. Care: Initiate CPR/Rescue Breathing/AED (if necessary)

1. The athlete should NOT be moved unless CPR cannot be administered due to obstruction/position, or the athlete's life is in danger due to environmental conditions.

NO EXCEPTIONS!!

D. Stay with the Athlete until EMS arrives:

1. A parent or member of the coaching staff should ride with the athlete to the hospital. The athletes' parents should be contacted and notified of the situation immediately.

EMERGENCY COMMUNICATION

Communication is the key to quick emergency response. Directors, Coaches & EMS must work together to provide the best emergency response capability and should have contact information established as a part of pre-planning for emergency situations.

Communication prior to the event is a good way to establish boundaries and to build rapport between professionals. If EMS is not available on site during a sporting event, then direct communication with the emergency medical system at the time of injury or illness is necessary.

The communications system should be checked prior to each practice or competition to ensure proper working order. A back-up communication plan should be in effect should there be failure of the primary communication system. It is important to know the location of workable telephones, be it Home or Away. Pre-arranged access to the phone should be established if it is not easily accessible.

Cell phones are usually readily available. The following is a list of important phone numbers needed in case of emergency:

Ambulance, Fire, Police Emergency.....	911
Christopher Witt (League Director)	631-774-4481
Terryville Fire Department	631-473-1224
Suffolk County Police Emergency Communications.....	631-852-6400
Suffolk County Poison Control.....	800-222-1222
Port Jefferson EMS.....	631-473-2519

EMERGENCY EQUIPMENT

All necessary emergency equipment should be at the site and quickly accessible. The highest trained member of the staff should determine in advance the type and manner in which any equipment is at or to be delivered to the site. Non-sports medicine staff members (including coaches, administrators, etc.) should rely on emergency medical services for all equipment. Personnel should be familiar with the function, operation, and location of each type of emergency equipment. Equipment should be in good operating condition, and personnel must be trained in advance to use it properly. Emergency equipment should be checked on a regular basis and rehearsed by emergency personnel to ensure comfort and proficient use of the equipment. The emergency equipment available should be appropriate for the level of training for the emergency medical providers. The Leagues Administrators & Coaches should be trained and responsible for the care of the medical equipment. It is important to know the proper way to care for and store the equipment as well. Equipment should be stored in a clean and environmentally controlled area. It should be readily available when an emergency situation arises.

Supplies Available: (AED, Med Kit - Exam Gloves, Breathing Barriers, Bandages and Dressings) are located at both John F. Kennedy Middle School & Comsewogue High School fields during practices/games

Emergency Equipment Location

Automated External Defibrillator (AED)

There are AEDs at both Field Locations.

John F. Kennedy Middle School AED is in equipment container in rear field on left side shelf.

Comsewogue High School AED is in the Black Game Day Storage Bin (This will Be at the 50 Yard Line for All Games)

CPR Masks – CPR masks are in the First Aid Kit, Located in Same Locations As AED.

First Aid Kits- Each Coach/Team Has 1 First Aid Kit In team equipment bag.

As well as a field specific First Aid Kit located in same locations as AEDs

VENUE SPECIFIC DIRECTIONS

John F. Kennedy Middle School

200 Jayne Blvd.

Port Jefferson Station, NY 11776



Comsewogue High School

565 N. Bicycle Path

Port Jefferson Station, NY 11776



LOCAL MEDICAL FACILITIES

John T. Mather Hospital

Main Hospital

75 North Country Road

Port Jefferson, NY 11777

(631) 473-1320

St. Charles Hospital

Main Hospital

200 Belle Terre Road

Port Jefferson, NY 11777

(631) 474-6000

Stony Brook University Hospital

Main Hospital

101 Nicolls Road

Stony Brook, NY 11794

LIFE THREATENING EMERGENCIES

Defined as an injury in which the individual's life is placed in danger and/or there is risk of permanent disability. In this situation the individual will need immediate proper medical attention and transportation to the hospital. Every second is crucial.

Examples of life-threatening injuries:

1. Sudden Cardiac Arrest
2. Suspected Neck & Spine Injury and/or Loss of Consciousness
3. Difficulty or Complete Stoppage of Breathing
4. Heat Illness
5. Uncontrollable Bleeding
6. Traumatic Brain Injury

CONCUSSIONS

Athletes suspected of having a concussion or head-related injuries are to be removed from participation immediately. Please notify the Director/Field Rep via cell phone or in-person immediately for evaluation.

Athletes who lose consciousness on the field must NOT be moved; stabilize head/neck and Call 911 Immediately.

Activate EAP if ANY of these symptoms occur:

- Significant head or neck injury
- Loss of consciousness or declining level of consciousness
- Worsening symptoms
- Persistent nausea or vomiting
- Neurological changes
- Seizures

LIFE THREATENING EMERGENCY ACTION STEPS

During a life-threatening emergency, follow the Emergency Action Steps (check, call, care) and provide appropriate first aid care. Provide EMS with the following:

1. Identify yourself and your role in the emergency
2. Specify your location and telephone number (if calling by phone)
3. Give age/condition of injured/ill athlete(s)
4. Give care being provided (CPR, AED, First Aid)
5. Give specific directions to the scene of the emergency
6. Do not hang up until directed to do so by the EMS dispatcher
 - a. Monitor vital signs
 - b. Calm and reassure the athlete
 - c. Notify Director/Field Rep as soon as possible
 - d. Notify parent(s) of athlete as soon as possible.
 - e. Provide follow-up care as necessary.

NON-LIFE-THREATENING EMERGENCIES

A non-life-threatening emergency is a situation that does not have an immediate impact on breathing, circulation, or brain function, but may still require medical attention. These injuries can be divided into those needing EMS service, and those needing Athletic Training service.

Non-life threatening emergencies that require EMS service include: Fractured limbs that are difficult to splint, dislocated joints where the person cannot be placed in a comfortable position, head injuries where the athlete's condition deteriorates upon re-evaluation, and severe bleeding that is not life threatening.

1. Stabilize the athlete
2. Call Director/Field Representative
3. Monitor Athlete
4. Decision to call for EMS will be made jointly by the coach and Director/Field Representative
5. When emergency medical personnel arrive, the coach releases care of the person to the paramedic or EMT

Non-life-threatening emergencies that require EMT service include:

Fractures, severe sprains of the major joints, joint dislocations, concussions, large contusions, and large open wounds that may need stitches. This may include any injury that is difficult to move without increasing the pain to the athlete.

1. Provide appropriate first aid care Notify the Director/Field Representative
2. If unable to contact the Director/Field Rep or unsure of the severity of the injury, send the athlete to the appropriate medical care facility if necessary
3. Notify the parent of the athlete if necessary
4. Provide follow-up care as necessary

GUIDELINES FOR PLAYERS/SPECTATORS **DURING A SERIOUS ON-FIELD INJURY**

1. Players and coaches should go to and remain in the bench area once medical assistance arrives.
2. Adequate lines of vision between the medical staff and all available emergency personnel should be established and maintained.
3. Players, parents and non-authorized personnel should be kept a significant distance away from the seriously injured player or players.
4. Players and non-medical personnel should not touch, move or roll an injured athlete.
5. Once the medical staff begin to work on an injured player, they should be allowed to perform services without interruption or interference.
6. Players and coaches should avoid dictating medical services to the EMT.

CATASTROPHIC EVENT- MULTIPLE **VICTIMS**

If a catastrophic event that involves multiple victims occurs, such as a bleacher collapse, the scene must be quickly assessed and triaged. Follow the same chain of command for any serious injury. When speaking to 911 dispatchers, give location and

number of victims (over-estimate). Victims that can walk should be led away from the scene, triage other victims. Those with life-threatening injuries will be given priority.

Triage Plan: A triage area will be established. The site should be a large enough area to accommodate the number of victims and must provide easy access for EMS vehicles and emergency apparatus. The triage site should be close enough in proximity to allow for quick but safe transport of victims while maintaining a safe distance from the accident scene. The concept of triage is simply a method of quickly identifying victims who have immediately life-threatening injuries and who have the best chance of surviving so that when additional rescuers arrive on scene, they are directed first to those patients. When the situation arises where there is a need to treat multiple victims, the Director/Field Rep at the site will be in charge of determining the order of care for the victims. All victims will be identified using athletic tape as follows:

IMMEDIATE – 1 strip of tape across chest for the serious, life-threatening injuries that need immediate care. These patients are at risk for early death - usually due to shock or a severe head injury. They should be stabilized and transported as soon as possible.

DELAYED – 2 strips across chest for moderate injuries that aren't immediately life threatening. Patients who have been categorized as DELAYED are still injured and these injuries may be serious. They were placed in the DELAYED category because their respirations were under 30 per minute, capillary refill was under 2 seconds and they could follow simple commands, but they could deteriorate. They should be reassessed when possible and those with the most serious injuries or any who have deteriorated should be top priorities for transport. Also, there may be vast differences between the conditions of these patients. Consider, for example, the difference between a patient with a broken leg and one with multiple internal injuries that is compensating initially. The second patient will need much more frequent re-assessment.

MINOR – 3 strips across the chest for mild injuries that require the least amount of emergency care. Ask those who are not injured or who have only minor injuries to identify themselves. Tag those with minor injuries as MINOR. Patients with MINOR injuries are still patients. Some of them may be frightened and in pain. Reassure them as much as you can that they will get help and transport as soon as the more severely injured patients have been transported. Any of these patients also could deteriorate if they had more serious injuries than originally suspected. They should be reassessed when possible. As a first responder and first one on the scene, not starting CPR may be the hardest thing you must do at a multiple casualty scene, but if you perform CPR on one patient, many others may die. The Athletic Trainer will assign doctors, coaches or trained bystanders to assist in care until AT or EMS can attend to athlete.

SUDDEN CARDIAC ARREST

Sudden cardiac death (SCD) is the leading cause of death in exercising young athletes. Sudden cardiac arrest (SCA) should be suspected in any athlete who has collapsed and is unresponsive. A patient's airway, breathing, circulation, and heart rhythm (using the AED) should be assessed. An AED should be applied as soon as possible for rhythm analysis. Myoclonic jerking or seizure-like activity is often present after collapse from SCA and should not be mistaken for a seizure. Occasional or agonal gasping should not be mistaken for normal breathing.

1. Initiate Emergency Action Plan
 - a. Follow Emergency Action Steps: Check, Call, Care
2. Cardio-Pulmonary Resuscitation (CPR) should be initiated within 1 minute of collapse
 - a. Targeted first responders (AT, coaches, security, game administrator/supervisors) must receive CPR/AED training and maintain certification
3. Goal of "shock" from a defibrillator (AED) within 3 minutes of collapse
 - a. Understand that in most communities the time from EMS activation to shock is 6.1 minutes on average
 - b. Appropriate training, maintenance, and access to AED's
4. Additional equipment to consider beyond AED
 - a. Breathing barrier device/pocket masks for rescue breathing
 - b. Bag-valve mask
 - c. Oxygen source
 - d. Oral and nasopharyngeal airways

HEAD & NECK INJURY

Athletic participation carries with it the risk of catastrophic cervical spine injury. Because of the potential for permanent neurological injury or death associated with cervical spine injury, proper on-field management is of utmost importance. Sports medicine professionals support the practice of not removing football helmets when there is even the slightest chance of cervical spine injury for the following reasons:

1. The football helmet does not hinder proper head and neck immobilization techniques.
2. The football helmet does not hinder the ability of the examiner to visualize facial and cranial injuries.
3. The football helmet with the facemask removed allows for proper management and control of the airway during CPR.
4. The football helmet will tend to protect against hyper-flexion of the cervical spine in the presence of should pads.

IMMEDIATE CARE OF ALL SUSPECTED SPINE INJURIES:

- Any athlete suspected of having a spinal injury should not be moved and should be managed as though a spinal injury exists.
 - The athlete's airway, breathing and circulation, neurological status, and level of consciousness should be assessed.
 - The athlete should not be moved unless absolutely essential to maintain airway, breathing, or circulation.
- If the athlete must be moved to maintain airway, breathing, or circulation, the athlete should be placed in a supine position while maintaining spinal immobilization.
- When moving a suspected spine-injured athlete, the head and trunk should be moved as a unit.
 - The Emergency Action Plan must be activated immediately.

FACEMASK REMOVAL:

It is imperative that all coaches, athletic trainers, team physicians and EMS personnel practice the use of the different face mask removal tools and familiarize themselves with how the face mask is to be removed from every helmet currently on the market.

The facemask should be removed prior to transportation, regardless of the athlete's respiratory status.

Those involved in the pre-hospital care of injured football players should have the tools for facemask removal readily available (screwdriver, power screwdriver, Trainer's Angel, FM Extractor, or a modified anvil pruner. A backup removal tool should also be on hand if a screwdriver is the first tool of choice).

FOOTBALL HELMET REMOVAL:

1. The athletic helmet and chinstrap should only be removed:

- a. If the helmet and chin strap do not hold the head securely, such that immobilization of the helmet does not also immobilize the head.
- b. If the design of the helmet and chin strap is such that even after removal of the facemask the airway cannot be controlled or ventilation provided.
- c. If the facemask cannot be removed after a reasonable period of time.
- d. If the helmet prevents immobilization for transportation in an appropriate position.

2. If the helmet does need to be removed:

- a. Spinal immobilization must be maintained while removing the helmet.
- b. Helmet removal should be frequently practiced under proper supervision. Specific guidelines for helmet removal need to be developed.
- c. In most circumstances, it may be helpful to remove cheek padding and/or deflate air padding prior to helmet removal.

LIGHTNING POLICY

The Comsewogue Youth Athletic Association has developed a lightning policy to minimize the risk of injury from lightning strike to CYAA athletes, coaches, support staff, and fans. Components of this policy include: monitoring local weather forecasts, designating a weather watcher, establishing a chain of command, and postponement of activities for 30 minutes from last lightning/thunder.

- If inclement weather is forecast for the area or sighted in the area, the designated weather watcher will monitor radar via the National Weather Service by smart phone or Internet.

www.weather.com

www.accuweather.com

- If lightning is in the immediate area, will notify the coaches as to the status of the inclement weather and need to take shelter. Teams may return to the field once 30 minutes from the last lightning/thunder has elapsed, and the all-clear signal has been given.
- **Safe shelter areas:** include fully enclosed buildings, fully enclosed metal vehicles with windows up (no convertibles or golf carts).
- **Unsafe shelter areas:** Water, open fields, dugouts, golf carts, metal objects (bleachers/fences), individual tall trees, and light poles.

In case of a lightning strike, follow these guidelines:

1. Survey the scene for safety.
2. Activate local EAP
3. Lightning victims do not carry an electrical charge and are safe to touch.
4. If necessary, move the victim with care to a safer location.
5. Evaluate airway, breathing & circulation, and begin CPR/AED if necessary.
6. Evaluate and treat for hypothermia, shock, fractures, and/or burns.

Event Procedures (Lightning)

Prior to Competition: The Director, Coach, Field Rep will greet officials, explain that we have means to monitor lightning, and offer to notify the officials during the game if there is imminent danger from lightning.

Announcement of Suspension of Activity: Once it is determined that there is danger of lightning in the area, the Director/Field Rep will notify the head coach and officials, and subsequently summon athletes (via horn, whistle, or PA) from the playing field or court.

Evacuation of the playing field: Immediately following the announcement of suspension of activity, all athletes, coaches, officials, support staff, and fans are to evacuate to an enclosed grounded structure

Evacuation of stands: During competition, once the official signals to suspend activity, a member of the CYAA support staff will announce Via Microphone

“May I have your attention. We have been notified of approaching inclement weather. Activity will cease until we have determined it is safe, and the risk of lightning is diminished. We advise you to seek appropriate shelter in automobiles. Thank you for your cooperation.”

Resumption of Activity: Activity may resume once the Director/Field Representative gives permission. Thirty (30) minutes after the last lightning/thunder.

EXERTIONAL HEAT ILLNESS

While exertional heat illness (EHI) is not always a life-threatening condition, exertional heat stroke (EHS) can lead to fatality if not recognized and treated properly. As the word heat implies, these conditions most commonly occur during the hot summer months; however, EHS can happen any time and in the absence of high environmental temperatures. Through proper education and awareness, EHS can be recognized and

treated correctly. While not all EHS cases are preventable, schools and institutions should have the equipment and supplies ready and available to properly assess and treat an EHS case. The two main criteria for diagnosing EHS are rectal temperatures >104°F (40°C) immediately post collapse and central nervous system dysfunction (e.g. irrational behavior, irritability, emotional instability, altered consciousness, collapse, coma, dizziness, etc.)

Follow these steps to initiate emergency treatment:

- Remove all equipment and excess clothing
- Cool the athlete as quickly as possible within 30 minutes via whole body ice water immersion (place them in a tub with ice and water approximately 35-58°F); stir water and add ice throughout cooling process. (See KSI Cold Water Immersion handout for step by step guidelines)
 - If immersion is not possible (no tub or water supply), take the athlete into a cold shower or move to shaded, cool area and use rotating cold, wet towels to cover as much of the body surface as possible.
- Maintain airway, breathing and circulation.
- After cooling has been initiated, activate emergency medical system by calling 911.
 - Monitor vital signs such as rectal temperature, heart rate, respiratory rate, blood pressure, monitor CNS status.
 - o If rectal temperature is not available, DO NOT USE AN ALTERNATIVE METHOD (oral, tympanic, axillary, forehead sticker, etc.). These devices are not accurate and should never be used to assess an athlete exercising in heat.
- Cease cooling when rectal temperature reaches 101-102°F Exertional heat stroke has had a 100% survival rate when immediate cooling (via cold water immersion or aggressive whole-body cold-water dousing) was initiated within 10 minutes of collapse.

RESPIRATORY DISTRESS

Shortness of breath or difficulty breathing in an athlete may have different causes. The Athletic Trainer or Physician (if present) should evaluate the cause. **If necessary, supplemental oxygen via nasal cannula or face mask should be started immediately. If pulse oximetry is available, SO₂ should be measured.** Auscultation of the lungs should be done. Based on the findings and on other signs and symptoms the following diagnoses should be anticipated and treatment should be started:

1. Asthma or Exercise Induced Bronchospasm (EIB)

- a. If wheezing or diminished air entry, consider acute asthma exacerbation.
- b. If patient is able, peak expiratory flow meter findings should be checked prior to and after albuterol inhalation.
- c. If patient improves, remove from athletic event for that day and follow up with their physician for asthma/EIB management.
- d. If patient does not improve significantly and/or SO₂ remains low they should be transported to the Emergency Department.

2. Anaphylactic Reaction

- a. Shortness of breath with signs of anaphylaxis;
- b. Flushing, itching, hives, sneezing, lightheadedness;
- c. Insect sting or history of previous anaphylaxis;
- i. EpiPen 0.3mg IM/SQ and transport to Emergency Department

3. Tension Pneumothorax

- a. Decreased breath sounds unilateral;
- b. Hyper-resonance to percussion- unilateral;
- i. If physician available, needle decompression on-site.
- ii. Transport to Emergency Department

4. Hyperventilation

- a. Rapid respiratory rate;
- b. Lungs clear on auscultation;
- c. Anxiety, lightheadedness, tingling in fingers and/or mouth;
 - i. Encourage patient to breathe slowly
 - ii. If no improvement, physician evaluation

If patient's symptoms do not improve significantly or the cause remains unclear, he/she should be transported to the ED. Other causes of difficulty in breathing include:

- Upper respiratory infections, Pneumonia
 - Vocal cord dysfunction
 - Pulmonary embolism
 - Cardiac causes
- Hematologic causes, e.g. Anemia

DOCUMENTATION

All actions and treatments pertaining to an emergency situation should be recorded on a standardized form. This is important for future reference for the EAP personnel. They need to be able to look back at the situation and response and improve or revise the EAP as they see fit. This will ensure better reactions and effectiveness for potential emergencies. The Director & CYAA Board of Directors will be mainly in charge of recording information. Doctors may assist if they provide care or treatment.

Documentation should include the following:

1. Documentation of response and actions during emergency situation
2. Follow-up documentation on evaluation of response to emergency situation

