

WSLL
Safety
Guide

2019

WEST SPRINGFIELD LITTLE LEAGUE (WSLL)
KEEPING BASEBALL FUN FOR EVERYONE

Guide to Safety and Child Protection

A PRACTICAL APPROACH TO LEADERSHIP AND FAMILY RESPONSIBILITIES
AT

West Springfield Little League

West Springfield Little League

Springfield, VA 22152
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West Springfield Little League: 48 Years in Service

WSLL Organization was formed in 1971

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AUTHORITY

BY UNANIMOUS ACTION OF THE 1965 LITTLE LEAGUE
INTERNATIONAL CONGRESS AND SUBSEQUENT RATIFICATION OF THE
BOARD OF DIRECTORS, IT WAS RESOLVED THAT EVERY CHARTERED
LITTLE LEAGUE SHALL APPOINT A SAFETY OFFICER

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OUR PLAYERS

FIRST AND FOREMOST

Help us create a safe and fun environment for all families

This document combines WSLI philosophies, policies, and procedures as they relate to running a safe and healthy Little League program for the Virginia youth of West Springfield, Burke, and Fairfax Station. Members of the Board of Directors, specifically the Safety Committee, have invested numerous hours in developing this comprehensive Safety Plan, implementing the program in our league, and educating our members and players toward preventing mishaps. Stay Safe!

All League Officials; Managers, Coaches, Umpires receive a copy of this plan. Printable versions of this document are available for download at www.wslbaseball.net

If you have any questions, comments, or suggestions about our program please contact our Little League Registered Safety Officer, Ken Nehilla, via email at kneh617036@aol.com



To be a superstar means you must stay alive to receive the cheers. Few can make a jump like this but all Little League players would like to try.

Safety is Priority One

Safety is stressed at all levels of play, practice and even idle time here at WSLI. Managers, coaches, parents, umpires, and volunteers are immersed in safety from league officials on a regular and prominent basis. Safety is paramount in all we do from inauguration of new board members, to the interview and selection process for our managers and coaches, to the operations at our facilities. Safety is reinforced to parents beginning at registration where they are educated on the steps WSLI takes to ensure the safety of our players, coaches, and families. Safety is an unwavering part of the league culture and a driving force behind all decisions made throughout our league.

Child Protection Program

Mandatory National Background Checks are performed with the Utmost Significance here at WSLL

Little Leagues world-wide are required to conduct background checks on Managers, Coaches, the Board of Directors (BOD), and any other person, ‘volunteers and hired workers’ who provide service to the league and/or have repetitive access to, or contact with, players or teams.

All such individuals are required to complete and submit a Little League Volunteer Application to a league official; Team Manager or higher in the organization. It’s a good idea to follow-up with the cleared volunteers list; checked, updated, and posted for each season, Spring and Fall, on the WSLL website showing all volunteers who have been cleared by this check.



Effective in 2007, each Little League International requires local leagues to conduct a nationwide search that contains the applicable government sex offender registry data specific to the individual being checked as well as a criminal background check. A Social Security Account Number (SSAN) is required to conduct this background check.

This search can only be completed with a valid ‘government issued’ identification showing your **current photo, date of birth, and residential home address**. The residential home address needs to match your current place of residence. Please do not consider this a wish list. It’s a requirement toward keeping our kids ‘our players’ safe and free to remain free.

Access a Copy of the 2019 Volunteer Application

[2019 Little League Volunteer Form](#) - If you need a hardcopy (printout) please contact the Safety Officer or any Board Member for assistance. The league has also transitioned to a background check process that is electronic, whereby the applicant submits their personal info via the website of an approved 3rd party, which processes the requests and forwards the results to the league Safety Officer. Both the paper and electronic submission formats are available to volunteers.

The form must be completed, signed and sent to your league safety officer along with a clearly legible copy of a valid ‘government issued’ ID and SSN as described above if the paper form is used.

PARENT'S GUIDE TO THE CHILD PROTECTION PROGRAM



Introduction

The backbone of Little League® is the adult volunteer. Over One million strong, it is this corps of dedicated people who coach the teams, umpire the games, work in the concession stands, serve on the local board of directors, and serve at the district level. These people, who live in every U.S. state and more than 100 other countries, make Little League the world's largest and most respected youth sports organization.

We know the greatest treasure we have is children. As adults, we must ensure these young people are able to grow up happy, healthy, and above all, **Safe**. Whether our children or the children of others, each of us has a responsibility to protect and report.

The Little League Child Protection Program seeks to educate children and volunteers in ways to prevent child abusers from becoming involved in the league. Part of that education has been to assist local Little League's find an effective and inexpensive ways to conduct background checks. ***Little League regulations now say: "must have all applicable personnel fill out the 2018 Volunteer Application Form as well as conduct a nationwide background check (Reg. I(b), Reg. I(c)8 and Reg. I(c)9).***

Background checks were optional until the 2003 season. Effective in 2007, the local league must conduct a nationwide search that contains the applicable government sex offender registry data. Advances in computer technology – allowing greater access to public records – makes it possible for background checks (at a minimum, to see if an individual is a registered sex offender in any given state) to be conducted in every U.S. state. Local Little League programs are now required to annually conduct a background check of Managers, Coaches, Board of Directors members and any other persons, volunteers or hired workers, who provide regular service to the league and/or have repetitive access to, or contact with, players or teams. (Reg. I [b], Reg. I [c] 9.)

The purpose of background checks is, First and Foremost, to protect children. Second, these checks help preserve Little League as a hostile free environment from those who would seek to cause harm to children. **Be Responsible – Be Adult – Protect and Guard!**

The United States Department of Justice National Sex Offender Public Registry is free and available to all citizens at www.nsopw.gov.

What Can Parents Do?

Most children have been warned about the dangers of talking to strangers. But for many children, sexual molestation is committed by someone they know. In fact, 80 to 85 percent of all sexual abuse cases in the U.S. are committed by an individual familiar to the victim, according to statistics compiled by Big Brothers & Big Sisters of America.



The truth is, child sex offenders can come from every background, every occupation, every race, and every level of education. They may be married, and they may have children of their own.

It is dangerous to believe the only threat is the stranger in a long raincoat, lurking behind a tree. **Not True!**

In fact, the promotion of this myth may contribute to the problem. Sometimes, a child who is molested by a known and “trusted” person will feel so guilty about not reacting the ‘correct way’ that he or she never reports the problem.

Sadly, we have all seen too many reports in which teachers, police officers, clergy, youth sports volunteers, etc., trusted by all, have violated that trust and molested children in their care. Of course, this must never be tolerated in Little League or anywhere else.

Two good rules to follow for all Little Leagues and parents

1. Generally, a person involved in a local Little League program should not put himself or herself in a one-on-one situation involving a child who is not their own. Of course, some isolated situations may arise where one-on-one situations could take place. However, a one-on-one situation should not be actively sought out by the adult, and should not be an ongoing occurrence.
2. Generally, a person involved in a local Little League program should not provide unwarranted gifts, trips, attention and affection to individual children who are not their own. The key word is ‘**unwarranted**’.

Warning Signs of a Seducer

While it remains important to teach young children about the dangers of accepting items from strangers, or talking to them, we should all beware of the danger posed by the “seducer-type” child sex offender.

Each of the individual signs below means very little. Taken as a group, however, the signs **MAY** point to this type of child sex offender, and should be applied to anyone who has repetitive access to, or contact with, children.

- Provides unwarranted gifts, trips, affection and attention to a specific child or small group of children
- Seeks access to children
- Gets along with children better than adults
- “Hangs around” children more than adults
- Has items at home or in vehicle specifically appealing to children, such as posters, music, videos, toys, and even alcohol or drugs

- Displays excessive interest in children (may include inviting children on camping trips or sleepovers)
- Single, over 25 years old (but could be married, sometimes as a “cover,” and could be any age)
- Photographs or videotapes children specifically
- Lives alone, or with parents
- Refers to children as objects (“angel,” “pure,” “innocent,” etc.)
- Manipulates children easily



Again, each of these items, by themselves, is relatively meaningless. Taken together, however, they may indicate a problem.

What to Watch For in Your Child

We’ve seen the signs that could point to a child sex offender, but what about the signs a child might display when he or she has been sexually abused or exploited? Some of these symptoms may be present in a child who has been or is being sexually abused. Such symptoms may not be otherwise explainable: sudden mood swings, excessive crying, withdrawal, nightmares, bed-wetting, rebellious behavior, fear of particular people or places, infantile behavior, aggressive behavior, and physical signs such as pain, itch, bleeding, fluid or rawness in private areas.

Getting More Information

These items are meant solely as a general guide, and should not be used as the only means for rooting out child sex offenders. Parents can access more information on child abuse through the National Center for Missing and Exploited Children (a non-profit organization founded by John Walsh, <http://www.missingkids.com/>) and the National Clearinghouse on Child Abuse and Neglect Information (part of a service of the Children’s Bureau, within the Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services).

How to Report Suspected Child Maltreatment

The National Clearinghouse on Child Abuse and Neglect Information advises this: If you suspect a child is being maltreated, or if you are a child who is being maltreated, call the Childhelp USA National Child Abuse Hotline at 1-800-4-A-CHILD (1-800-422-4453; TDD [text telephone] 1-800-2-A-CHILD). This hotline is available 24 hours a day, seven days a week. The Hotline can tell you where to file your report and can help you make the report.



Or, for a list of states’ toll-free telephone numbers for reporting suspected child abuse, call the Clearinghouse at 1-800-FYI-3366 or visit the “Resource Listings” section at this site: <https://www.childwelfare.gov/>

Talk to Your Kids; Listen to Your Kids

It is important that you as a parent talk frankly to your children. If a child reports sexual abuse, statistics show he or she is probably telling the truth. Unfortunately, the sexually molested child often sees himself or herself as the one “at fault” for allowing abuse to happen. Your

children **MUST** know that they can come to you with this information, and that you will support them, love them, and believe them.

If there is an allegation of sexual abuse of a minor, the crime should be reported immediately.

Criminals who steal or intend to steal a childhood **MUST BE STOPPED.**



This advice was produced by Little League Baseball, Incorporated; P.O. Box 3485; Williamsport, PA 17701

Little League Baseball and Softball does not limit participation in its activities on the basis of disability, race, creed, color, national origin, gender, sexual preference or religious preference.

Chapter
2

Attitudes Make the Difference

Everyone’s approach to the challenge of accident prevention must be from a positive point-of-view to be effective. We should be concerned primarily with Risk Avoidance; controlling the causes of incidents which can be eliminated without taking excitement, action, speed or competition out of the game. An attitude of alertness, hustle and enthusiasm without aggression should be encouraged.

Good sportsmanship and courtesy, which are necessary for a harmonious and safe environment, is best taught through good examples set by adults on and off the field.

Your most effective tool to inspire an attitude of self-confidence and a desire to excel is the use of much PRAISE and RECOGNITION. Of course, this must be given when deserved so as not to be cheapened by too much repetition. After all, a really good try rewarded by a word of encouragement may be 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. *It is emphasized that good training is the most effective weapon against accidents caused by unsafe acts.*

<p>Little League Pledge I trust in God I love my country and will respect its laws I will play fair and strive to win but win or lose I will always do my best</p>	<p>The Little League Parent/Volunteer Pledge I will teach all children to play fair and do their best I will positively support all managers, coaches, and players I will respect the decisions of the umpires I will praise a good effort despite the outcome of the game</p>
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Safety is a Responsibility

In order to understand the reasons for a Safety Program, we should look at why Little League has been so successful.

Former President Bush said, "Years ago, when I played on those dusty LL fields in West TX, I never dreamt I'd be President ...One thing I did dream about though, was making it to Williamsport for the Little League World Series ...I equate LL Baseball with good family values and tradition."



Little League Policy

One of the reasons for Little Leagues' wide acceptance and phenomenal growth is that it fills an important need in our free society. As our program expands, it plays a major part in the development of young people. It instills confidence and an understanding of fair play and the rights of other people.

Those who develop slower than others are given an opportunity not only to develop their playing skill but to learn what competition and sportsmanship are all about. All who take part in Little League programs are encouraged to develop a high moral code along with their improvement in physical skills.

Safety Responsibility

The founding principle of Little League to provide an opportunity and new experience for youngsters, multiplies the exposure to possibility for accidental injury. Having accepted this large group of partly developed fledglings, we must also accept the moral responsibility for their safety. **This obligation rests with every adult member;** which includes inactive parents who drop their kids off entrusted their children to coaches. Don't go too far. Watch, learn, and participate.



“Safety” is Core to WSLC Culture is made available to all; specifically our Managers, Coaches, Umpires, Team Parents, Fields and Facilities Staff, Concessions Staff, General Volunteers, and all members on the Board of Directors.

Fundamentals of Safety and First Aid Training: is scheduled for early March, 2019, in the Irving Middle School cafeteria from 7pm to 9:30pm. A second date is available for late March if necessary. We ensure all teams

are represented and each manager and coach needing a 3-year update is included & participates as well as a parent from their team every season. This manual will be issued to all teams and is present at all times for reference in each concession stand and equipment locker throughout the league. The softcopy version is available at LINK below.

LINK to the 2019 Safety Plan – Complete Edition

- <http://www.wslbaseball.net/>

Authority – League Safety Officer

League Safety
Officer

By unanimous action of the 1965 Little League International Congress and subsequent ratification of the Board of Directors, it was resolved that every chartered Little League shall appoint a Safety Officer.

Qualifications

The League Safety Officer should be someone having the following qualifications, at least to a reasonable degree:

1. Sufficient knowledge of baseball and softball to evaluate and suggest corrective measures for hazards without conflicting with Little League Rules.
2. It would be an asset if this person has firsthand experience with a safety program, or at least an understanding of the importance of safety.

3. Examples of people with indirect knowledge of safety would be doctors, insurance agents, and fire or police officers.
4. Such an officer should be a person who can adapt a point of view to that of other volunteers. In other words, the officer should be able to sell a safety package on its own merits.
5. The officer should have the interest and the time to coordinate the safety efforts of other adults in the organization.

League Safety Officer's Authority

The League Safety Officer's authority is mainly advisory with as much force behind advice as the league president has delegated that officer. It must be remembered that managers, player agents and umpires must carry out their own duties and responsibilities. Any differences of opinion on safety policy should be referred to the League President rather than argued. Further questions may be taken up with the District Safety Officer. The latter may refer such problems to Little League Headquarters.

Responsibilities

The responsibility of a League Safety Officer is to develop and implement the league's safety program. The following may help in carrying out the duty.

1. Spot checks should be made at practices and games to be sure reasonable precautions are taken and assist wherever possible with advice and encouragement.
2. At the playing field, the League Safety Officer's first duty is to insure first aid facilities are available and emergency arrangements have been made for an ambulance or doctor.
3. The League Safety Officer's next obligation is to advise and follow up on the control of unsafe conditions. These will be brought to light by the adults in charge making a preliminary inspection of the field and being continually on the lookout for situations that might cause accidents. Since it would not only be impossible, but an invitation to "buck passing," for a League Safety Officer to keep a degree of control over accident exposures alone, such efforts will be effective only when the officer and league president have convinced fellow volunteer workers that safety should be a primary consideration in whatever they are doing.
4. In addition to the League Safety Officer's advising on the control of unsafe conditions throughout the season, it is a specific responsibility to follow up on procedures and methods of instruction that will help control the human elements which may be the cause of accidents. Here again the work must be done through existing lines of authority in the organization to make accident prevention a matter of league policy rather than an afterthought applied on a hit-or-miss basis.
5. It would be suitable if the League President delegates the handling of insurance claims to a League Safety Officer because:
 - A League Safety Officer will be familiar with accidental injury cases that require an insurance claim.
 - The personal knowledge of the people in the league will be helpful in following up on such cases.
 - The League Safety Officer will recognize the pain and hardship which result from such injuries, and will serve as an additional incentive to see that everyone is kept on their toes to prevent the occurrence of other accidents.

Safety Plan Structure

The first duty of a new League Safety Officer is to sit down with the League President and prepare a safety program for the league. This WSLL Safety plan is available and distributed at the start of each season to WSLL families as requested. It has the essential objectives of assuring that:

1. Practice and playing field conditions are made as safe as possible.
2. Players protective equipment and facilities are available and in good condition.
3. Arrangements have been made for first aid treatment and emergencies.
4. All managers, player agents, coaches and umpires have been instructed to include all suitable safety precautions as an integral part of their regular duties.
5. Other volunteers, such as grounds keepers and auxiliary members are carrying out their jobs safely.
6. A definite plan is in effect for traffic safety including player travel field.
7. Arrangements are made for the prompt investigation and reporting of accidents and near-misses with a definite follow up for the prevention of further accidents of a similar nature.
8. Procedures are in place for prompt and timely reporting of accidents requiring medical treatment to Little League Headquarters.

If this safety plan and program is to be effective, League Officials must not only agree that safety is essential to the operation of our Little League, but that they will do their part to make it succeed.

Safety Committee Introduced

WSLL has an active Safety Committee chaired by the Safety Officer which reviews safety programs and training to ensure the league is doing all it can to guarantee a sound and effective program is implemented. The committee develops the safety plan, approves and schedules training, reviews fields, facilities, and player equipment to ensure they meet Little League Safety Regulations. This WSLL Safety plan is available and distributed at the start of each season to WSLL families as requested and is available on the WSLL web site. The committee may consist of League Officials, Board Members, and Dedicated Volunteers. In 2018, the Safety Committee Members are:

- League President – Mike Warbel
- Safety Officer – Ken Nehilla
- Chief Umpire: Al Beyer-Majors, Ralph Yates - Minors; Fields Manager (Byron): Dave Pollack; Fields Manager (Burke): Steve Puryear; Equipment Manager: Scott Mills; Concessions Manager: Shannon Matheny; Executive V.P., Mike Williams; V.P. Communications: Matthew Waggoner; V.P. Baseball Operations: John Mielcarek; V.P. Challenger Baseball: Eddie Garretson; Fall Baseball Commissioner: Mike Williams

Safety Training and Equipment

Managers and coaches must complete a WSLL-approved safety class at least once every 3 years as well as a parent from each of their teams on an annual/season basis. The class's purpose is designed to provide safety training to enable coaches to recognize and react appropriately to common injuries and conditions encountered by youth baseball coaches. The Safety Officer will be responsible for developing and administering this training,

furnishing evidence of training to those who successfully completed the class, and maintain a roster of those attending. Maintain files on the safety officer section of the BOD website.

- **For emergencies** - Teams/Managers must have quick access to a phone and cellular phone coverage is available at every WSLI practice and playing field. In addition, WSLI fields have first aid kits contained in the field equipment box or at Byron, concession stand and equipment shed.



In addition to Safety Training, WSLI pays for interested coaches to attend organizations affiliated with our Districts Little Leagues. WSLI coaches are encouraged to attend the clinics through Metropolitan Baseball Academy, 8190 Newington Road, Lorton, VA, 22079.

The Safety Role an Umpire Must Perform

Umpire (baseball) - *Defining the word Umpire* One who acts as arbiter of a dispute between two people or teams, where the arbiter is not paired with anyone in the dispute.

In baseball, the umpire is the person charged with officiating, begins and ends the game, enforces game rules and grounds surrounding the field, making judgment calls on plays and handling disciplinary actions that influence the game.

Judgment calls - Unlike referees in American football, an umpire's judgment call is final, unless the umpire making the call chooses to ask his partner(s) for help and then decides to reverse it after the discussion. If an umpire seems to make an error in rule interpretation, his call, can be officially protested. If the umpire is persistent in his or her interpretation, the matter will be settled by a league official.

Rule 9.01(a) – The umpire shall be responsible for all conduct and for maintaining discipline and order on the playing field throughout the game. Non-adult umpires may supplement the umpire crew but the umpire-in-chief must always be an adult.

Rule 9.03(d) – If no adult umpire is available for a game, and non-adult umpires are used exclusively for that game, the local Little League must assign an adult as Game Coordinator, or the game cannot be played. The Game Coordinator must not be a manager or coach of either team in the game.

Keep it Real: One of the toughest positions to fill in Little League is the role of Volunteer Umpire. The primary reason most candidates either refuse to participate or quit as a Volunteer Umpire is due to the manner in which they get treated by parents, spectators,



coaches, and sometimes players that disagree with a call. Keep this in mind; these volunteers are working hard, learning, and improving with every game. While the critics are often sitting with the hope and expectation that most calls will go in their team's favor. Umpires can make mistakes. All people make mistakes. Just keep it cool and keep your expectations, In Check!

Do not expect total perfection – live and let live

**** All judgments and rule interpretations are the responsibility of the Umpire**

Umpire Safety Gear

Umpires who perform this job are trained and are aware of the safety needs for using the proper safety equipment. However, parents from the stands may be asked to perform this job. When this day comes; you need to know where the equipment is located, what equipment is needed, and what equipment is on hand. WSL provides umpire equipment that's stored at each game location and shared from game to game. The equipment at Byron can be found in the central tool shed next to the concession stand. Equipment at Burke (Fenway) can be found in the tool shed behind concessions. And umpire gear at each of the satellite elementary schools; (West Springfield, Rolling Valley, and Keene Mill) can be found in the locked equipment boxes behind each of the field backstops.

Rule 9.01(except) – The plate umpire, like the catcher, must wear a chest protector, facemask with 'preferably' a throat guard, and shin guards. Male umpires must wear a protective cup (wrap-around cup preferred). Umpires who have their own equipment often add steel toed shoes to the mix and shanks that cover laces. It seems to help.

WSLL ADMINISTRATIVE POLICIES

INTRODUCTION – Policy and Guidance

The purpose of the WSLL Policy Manual is to provide its members a guide to the operations and procedures of the West Springfield Little League throughout the year. Operating a Little League the size and scope of West Springfield's is a year-round endeavor, involving countless volunteers and hundreds of separate tasks. This Manual is approved by the WSLL BOD and represents its best and most considered view as to how the many volunteers that constitute the staff and personnel of the League should conduct their assigned responsibilities.

Board of Director
Code of Conduct

- Treat each other and league members with courtesy and respect
- Perform their assigned duties diligently, or ensure a replacement is obtained for doing so
- Observe rules regarding confidentiality of the information they receive and never use confidential information to advance their own interests
- Conduct themselves in a manner that honors board membership & league

Conduct Subject to Disciplinary Actions

The following represent a non-exclusive list of actions that could warrant some level of disciplinary action.

- Ejection from a game
- Physical confrontation of any kind
- Use of abusive language to a player, parent, umpire or other coach
- Multiple violations of Little League mandated safety rules
- Any use of vulgar language at either games or practice within the confines of the playing fields

Conflicts of Interest

- Should the execution of assigned responsibility by a Board Member result in either perceived or actual conflict of interest, the member shall recuse him/herself by notifying the League President of the conflict. An example of this would be a Board Member with a child on a Baseball Academy travel team having input into who receives the League's training contract where said Academy is bidding.

Maintenance of WSLL Documents

Vice Presidents will ensure committee heads maintain files that are necessary to carry out their duties and that they are passed on to their successors. Files will be dated so as to facilitate their retrieval and observance of the retention policy.

Specific Files

The President will ensure the league maintains files relating to the league's legal status and charter, finances, league correspondence, manager selection, manager evaluation, and manager /coach/officer disciplinary actions. The Player Agent will maintain all files relating to player evaluation and discipline. The Treasurer will maintain all finance, audit, and tax records.

Retention of Documents

Documents related to the conduct of WSLL affairs should be retained as set forth:

- Files relating to disciplinary matters will be retained for at least five years
- General Correspondence will be retained for at least seven years
- Files will be maintained beyond the retention period stated above
- Files may be destroyed at the end of their mandatory retention period with approval of the Executive Committee



WSLL Gray Book

The league will distribute printed WSLL Regulations and Rule Book supplements, otherwise known as “Gray Book,” to each manager, coach of record, umpire, and board member, and publish the annual version on its website. The book contains all local rule restrictions and those regulations affecting behavior, player assignment, team formation, manager and all-star selections, safety plan, and other rules managers should have at their ready disposal. The book also will contain a summary of manager responsibilities and other matters of concern for managers, including equipment, field care, volunteer background checks, levels of play (for evaluation purposes), player and manager evaluations, sexual harassment, and child abuse.

It is expected that each manager, coach of record, umpire, and board member, will read and become familiar with the contents of the WSLL Gray Book.

Privacy Policy

This policy will be enforced by the Safety Officer in conjunction with the Vice President associated with the related data for their area of responsibility.

DATA COLLECTED AND PURPOSES

Information collected to comply with Little League Baseball, government requirements, and to facilitate team or volunteer organization. Typical uses include, but are not limited to the following:

- Personal information from players, managers and volunteers to facilitate league and to satisfy Little League's volunteer background investigation
- To Little League baseball, the league is required to submit names, addresses, gender, (players) and dates of birth (players)
- The League is required to submit player address information to Fairfax County to comply with field permit requirements
- When the league purchases additional insurance, information may also have to be provided to its insurers
- E-mail addresses to communicate with parents and members. The League will limit e-mails to matters concerning league operations, matters of interest to the league, and to facilitate communication of team data
- Evaluation data about players, managers, and coaches to assist in the formation of teams, selection and training of managers, and selection to All Star squads. These include: manager evaluations of team players; player tryout evaluations; parent evaluation of managers; and letters of complaint about particular managers or coaches

CONDITIONS OF COLLECTION

Data of the sort set forth here is extremely sensitive. It may never be used for any purpose other than furthering league objectives, such as described above. It may not be sold or provided to any person or entity outside the league except as required to operate the league.

When data is distributed electronically, special care must be taken to limit distribution to those with a need to know and who understand and will abide by data disposition rules.

DATA WILL BE DISPOSED OF AS FOLLOWS:



Evaluation and tryout data will be deleted when its use is no longer relevant. For instance, tryout data will be deleted at the conclusion of the draft, manager evaluations deleted after manager selection, etc. Specific retention and disposal instructions are provided in the League's Records Retention and Disposal Policy.

The data must be protected from inadvertent release. Archive player and volunteer databases will be maintained by the League.

Individually maintained or created databases in any form are prohibited.

Compliance with this policy is the responsibility of anyone who comes into possession of data subject to this policy. The League Officer who disseminates any such information will

ensure that anyone to whom he or she releases it is aware of this policy and agrees to abide by it.

League volunteers furnished data must take every effort to ensure the data is safe while under their control. This includes maintaining updated operating system and browser software and ensuring an antivirus program is installed and kept current. Any volunteer who does not certify that they are in compliance with these requirements may receive paper copies of information.

Violation of this policy may result in up to revocation in League Membership.

WEB CONTENT POLICY

In order to ensure the privacy and safety of our players and families, the following applies to all content published on WSL's controlled sites or sites established to communicate information about WSL, its players or families:

**** Pictures posted of children will NEVER include names.**

- Managers may establish their own web sites to communicate information about the team to players and parents
- Although WSL does not control those web sites, the league offers the following guidance and will assist parents in resolving any dispute concerning a failure to follow these guidelines
- Web sites should be deactivated at the conclusion of the season
- If the site is open, personal information is limited to first names of players (last initial OK) and parents. If the site is secured via password, team contact information may be included
- Individual statistics should never be posted on a web site

STANDARDS FOR WSLM MANAGERS AND COACHES

Manager's personality is an important factor in success of Little League Baseball.

Positive Coaching Alliance (PCA)

WSLM Board of Directors has entered into a partnership with the Positive Coaching Alliance (PCA). This partnership will allow us to combine efforts to further provide support and training for our dedicated coaches. WSLM Coaches Clinic and PCA Seminars are scheduled for recurring presentations as needed.

As with the core values of Little League International, in the PCA Double-Goal Coach® model, coaches are taught winning is one goal and teaching life lessons is the second, more-important goal.

PCA was created in 1998 by founder Jim Thompson with the focus on transforming the culture of youth sports to provide all youth athletes a positive, character building experience. The Board of Directors looks forward to this partnership and working together with our Managers and Coaches to continue to enhance the baseball experience of our Youth Players.

For more information on the PCA, go to <http://www.positivecoach.org>

LEADERSHIP

The following characteristics are expected of all WSLM Managers and Coaches, as well as, league officials:

- Exercises their leadership role adequately but leaves the ball game in the hands of the players
- Accepts responsibility, and is well organized
- Has a good understanding of the emotional and psychological characteristics of pre-adolescents
- Has a good rapport with each player and tries to understand the personal needs and challenges of players and adjusts accordingly
- Disciplines fairly, impartially, suited to the age level of the players, and is done by using good judgment and honor
- Actively participates in League functions including volunteer activities at WSLM functions

Disposition - Is pleasant, courteous, even tempered, sympathetic, enthusiastic, and has a sense of humor.

Poise - Behaves in an adult manner, maintains self-control, and is aware they are an example to those with whom they work.

Character - Is sincere, truthful, and demonstrates an appreciation of the philosophy of Little League Baseball by cooperating with others in making the program a mutual benefit to all youngsters.

Appearance - Always practices good health habits, dresses suitably and is properly groomed.

Relations with others:

The nature of a manager's work brings him into closer contact with many people.

With Parents – Requires interpersonal communication with many people. Seeks their cooperation and understanding in trying to achieve the goals of the Little League program. The following expectations are set forth: displays friendliness, courtesy, and shows consideration for their opinions and feelings.

With Colleagues - Is friendly, cooperative, courteous, and considerate

With Game Officials - Shows by example, respect for the judgment and the position of the umpire; avoids bickering and “umpire baiting.” Is cautious and uses sound judgment in a protest situation; avoids protests where possible.

Coaching Duties: Should have proper knowledge of ‘baseball’ - its fundamentals and its strategy.

- Organizes practice sessions, teaches fundamental skills and game strategy at the players level using various drills.
- Schedules practice sessions that are well spaced so they do not become a chore for players and managers.
- Takes adequate precautions to prevent accident or injury including maintenance of protective gear.
- Ensures that players are kept from reaching extreme limits of physical and emotional fatigue.
- Has knowledge of safety and first aid.
- Continually encourages players at every opportunity.
- Instills the desire to win, to improve all players skills, and to understand team concepts, yet at the same time to have fun.
- Knows the playing Rules of and Regulations of Little League, is able to interpret them correctly, plays by the rules and adheres to their intent, and instills in their players to respect the rules of the game.
- Observes all WSL Local Rules, with particular attention to player participation.

Develop Desirable Habits in Players

- Encourages promptness, clean living and good health habits, and responsibility and leadership.
- Encourages good sportsmanship and fair play at all times by teaching good behavior; congratulating opponents after each game; accepting defeat gracefully; and accepting victory humbly.
- Instills in their players a respect for the authority of adult leaders.

League Safety 101 – Summary

General Safety

- Fundamentals of Baseball Training is planned in collaboration with NOVA South, Woodbridge, VA. Exact dates and times will be shared with incoming Managers and Coaches when scheduled.
- Good training is the most effective tool against accidents caused by unsafe acts.
- Safety is stressed at all levels of play, practice and even idle time here at WSLL.
- First-Aid Kits (what goes inside - general bandage materials and gauze)
- Everyone’s approach to the challenge of accident prevention must be from a positive point-of-view.
- Good sportsmanship and courtesy, which are necessary for a harmonious and safe environment, is best taught through good examples set by adults on and off the field.
- **Team Web Sites** - Managers may establish their own web sites to communicate information about the team to players and parents. Although WSLL does not control those web sites, the league offers the following guidance and will assist parents in resolving any dispute concerning a failure to follow these guidelines:
 - Web sites should be deactivated at the conclusion of the season.
 - If the site is open, personal information is limited to first names of players (last initial OK) and parents. If the site is secured via password, team contact information may be included.
 - Individual statistics should never be posted on a web site.
- **Safety Training and Equipment** - Managers and coaches or record must complete a WSLL-approved safety class at least once every 3 years as well as a parent from each of their teams on an annual/season basis. The class’s purpose is designed to provide safety training to enable coaches to recognize and react appropriately to common injuries and conditions encountered by youth baseball coaches.

Concussion Awareness

Managers and coaches of record will complete a WSLL-approved concussion training class required by the State of Virginia. The State of Virginia has accepted a requirement for Interscholastic Sports Coaches to have Concussion training. WSLL "Concussion Awareness" Training. WSLL Managers, Coaches, and Board Members will take a Free course option, provided by VA District 9 that meets the training requirements as well as the newly implemented states requirements. (Course can be found at: http://www.cdc.gov/concussion/HeadsUp/online_training.html)

WSLL falls under this because we use Fairfax County Public School grounds for our activities. WSLL has to institute this to have ourselves covered in case this comes to the Board from District or from Fairfax County School authorities.

Where We Stand on League Safety

Fields, Equipment, Rules, Facilities and Policy

The more we change, the more additional change becomes apparent

Just like this Safety Plan, change is never ending. The first baseball thrown under the name Springfield LL was in 1956. Since that day, our league has been building, changing and making improvements.

The most recent and significant safety improvements have been in the areas of Fields and Equipment. Second only to our volunteers; fields, concession activities, and equipment are the staples to any league's success. A special thanks needs to go to our leaders in these areas for performing an over-the-top job of making things happen 'for each and every one of us'. Don't forget to thank them and help often.

- Chief Umpire – Al Beyer
- Fields Manager (Byron) – Dave Pollack
- Fields Manager (Burke) – Steve Puryear
- Equipment Manager – Scott Mills
- Concessions Manager – Shannon Matheny

Game Fields

The Little League Field Survey is attached as an appendix to the Leagues' Safety Plan

Yankee Field - This field supports play at all levels of play, T-ball, A, AA, AAA, and Majors play with artificial lighting, electronic scoreboard and PA system.

Wrigley Field - The field was rebuilt from the bottom up to continue supporting all levels of play T-ball, A, AA, AAA, and Majors games with lighting, electronic scoreboard, and PA system. During the summer of 2012, Wrigley was the first of two fields available to support Intermediate 50/70 level baseball games.

Fenway Field – Fenway way built in 1999 and has grown into a world class LL diamond supporting A, AA and AAA games. In the fall of 2012, the infield at Fenway was graded to level and the field was recreated to little league



standards as originally implemented, as well as, the second WSLL field made convertible for 50/70 level baseball games.

Ebbets Field – One of our busiest fields supporting A/AA/AAA games with only the basics.

Forbes Field & Three Rivers Field – These are primarily for T-Ball and A.

Note: As part of pre-game preparations, a member of the HOME TEAM coaching staff and/or the umpire shall walk each field for potential hazards and share those at home plate discussion before each game. If warranted, the hazard should be brought to the attention of the WSLL Safety Officer and Fields Manager.

Baseball Equipment

Bats

Our equipment budget continues to be updated with team bats as warranted. In 2018, Little League bat regulations were amended. The changes included a maximum barrel size of 2 5/8” and an approved “USA Baseball” label to be present on each bat intended for use in regulation and tournament play. This mandate was issued to mitigate the increasing risk of batted baseballs rebounding back toward defensive players ‘too quickly’.

Note: There’s no requirement for parents to buy bats for any level of play at WSLL. The league provides each team with high quality bats meeting all safety requirements.



Starting in 2018, non-wooden bats used in Little League Baseball (Majors Division and younger) must have this logo in order to be used in competitive play. Without it, the bat is not legal and will be removed.

Rule 1.10 Excerpt – Baseball Bats

The bat must be a baseball bat which meets the USA Baseball Bat standard (USABat) as adopted by Little League. It shall be a smooth, rounded stick, and made of wood or of material and color tested and proved acceptable to the USA Baseball Bat standard (USABat).

Beginning with the 2018 season, non-wood and laminated bats used in the Little League (Majors) and below, Intermediate (50-70) Division, and Junior League divisions shall bear the USA Baseball logo signifying that the bat meets the USABat – USA Baseball’s Youth Bat Performance Standard. All BPF – 1.15 bats are prohibited. Additionally, the bat diameter shall not exceed 2 5/8 inches for these divisions of play. Additional information is available at LittleLeague.org/batinfo.

TEE BALL:

Under the USABat standard, certified Tee Ball bats (26" and shorter) will feature the USA Baseball mark and text which reads ONLY FOR USE WITH APPROVED TEE BALLS. All Tee Ball bats must feature the USA Baseball mark and accompanying text. Tee Ball bats that were produced and/or purchased prior to the implementation of the new standard can be certified using an Approved Tee Ball Sticker via the USA Baseball Tee Ball Sticker Program (USABaseballShop.com) beginning September 1, 2017.

MINOR/MAJOR DIVISIONS:

It shall not be more than 33 inches in length; nor more than 2⁵/₈ inches in diameter, and if wood, not less than fifteen-sixteenths (15/16) inches in diameter (7/8 inch for bats less than 30") at its smallest part. Wood bats taped or fitted with a sleeve may not exceed sixteen (16) inches from the small end.

NOTE: Solid one-piece wood barrel bats do not require a USA Baseball logo.

The bat shall be made of wood or of composite material tested and proven acceptable.

For all games played at WSL, the bat shall not be more than (33) inches in length nor more than (2 5/8) inches in diameter.

In all divisions, wood bats may be taped or fitted with a sleeve for a distance not exceeding (16) inches. A non-wood bat must have a grip of cork, tape, or composition material that extends minimum of (10) inches. Slippery tape or similar material is prohibited. An illegal bat or bat that has been altered shall be removed from play immediately.

Batting donuts or weights placed on bats are not permissible (not allowed) at practice or games.

Uniforms - Our League

Our league provides uniform shirts, baseball pants, socks, and a baseball cap to each player with sequential numbers on the back. We also require players be properly dressed for baseball activities before and for all games and practices. Each article of covering serves a real purpose toward keeping players safe. Long baseball pants, socks and properly cheated shoes help to protect the lower body from scraps, cuts and falls while fielding or sliding into base. The cap is vital for helping keep sunlight out of players' eyes. Practices without sliding or fielding could be held with players wearing shorts and regular athletic shoes. However, the cap is still required and a shorts option must be pre-arranged with your team manager or a coach of record who's running the practice.

Rule 1.11(Excerpt) - Baseball Uniforms and Wearable Items

Item (a.3) – Any part of the pitchers undershirt or T-shirt exposed to view shall be of a solid non-white, nor gray in color. A pitcher shall not wear any items on his/her hands, wrists, or arms which may be distracting to the batter. Basically, anything a pitcher could wear that would or could prevent a batter from detecting the incoming ball 'in time' to get out of the way, should be avoided.

Item (k) – Casts may not be worn during the game by players and umpires. **Note:** persons, including managers and coaches, wearing casts must remain in the dugout.

Rule 1.17 – All male players must wear athletic supporters.

Personal Protection Cup – Athletic supporters are required for all players, but the metal, fiber, or plastic type cup protection is required for male defensive players in the catcher position. We at WSLI would highly recommend parents and team managers encourage all players to wear the cup protection. It's especially recommended at the AA, AAA and Majors level, increasing in severity in that order. There's also a female pelvic protector available that is equally recommended. The goal is to keep players safe, in the game, and having fun.

Catchers Gear - All Divisions of Play

Rule 1.12(excerpt) – The catcher must wear a catcher's mitt (not a first baseman's mitt or fielder's glove) consistent with protecting the hand.

Rule 1.17(excerpt) – All catchers must wear long or short model chest protectors with neck collar, shin guards, and a catcher's helmet with throat guard. Male catchers must wear cup protection. **Note:** All catchers must wear a mask, 'dangling type' throat protector with catcher's helmet during practices, pitcher warm-ups, hitting infield or shags, and in all games.

No Exceptions!

Warning! Manufactures have advised that altering helmets in any way can be dangerous.

Batting Helmets - All Divisions of Play

Per **Rule 1.16** – WSLI provides each team with six (6) protective batting helmets that meets NOCSAE specifications and standards.

- Use of the helmet by batters, base runners, on-field bullpen 'observer', and youth base coaches is mandatory.
- Use of a helmet by an adult base coach is optional.

Do not alter helmets: paint, add decals, or tape unless approved in writing by the helmet manufacturer or dealer. Names or numbers should be written on the underside of the helmet visor/bill.

Per Little League International 2015 – Helmets must have a non-glare surface and cannot be mirror-like (or chromed) in nature at any division/level.

Baseballs - Tee Ball, Minor League, Majors Level

WSLI provides new and used Little League Approved game baseballs and issue practice baseballs to each team; age appropriate. 5-T and T-Ball use a softer baseball.

Face Mask and Mouth Guards

Little League regulations do not require players at any level of LL Baseball to wear a batting helmet with face shield. It is Managers, Coaches, Parent discretion for players at the A/AA levels wear face shields. This would help players at these levels gain confidence while growing their baseball skills.

Food Concessions

We have concessions at Byron Park, safe grilling, serving, and sanitary safety practices are required and are in place. It is recommended by Fairfax County Park Authority and WSLI Board of Directors that anyone interested in working the concession stand should review the food handling information available at <http://www.fairfaxcounty.gov/hd/food/> . [Note:

Effective July 1, 2013, a Health Department Permit to Operate is no longer required to serve food from a youth athletic concession stand. In the past, the Health Department has conducted food safety workshops for volunteers who work at the concession stands. It is no longer required that volunteers attend the food safety workshops.]

Our main goal at WSL is to remember to have clean hands and a clean working environment to serve our families. Remember to ***Clean, Separate, Cook and Chill!*** Food safety brochures are available upon request from the Health Department and Cooking for Groups: A Volunteer's Guide to Food Safety is a good resource available from the USDA. If you have any questions, please contact the Health Department.

Grilling Safety

According to the Insurance Information Institute, backyard barbecues result in more than 2,000 fires and even three deaths each year. Most problems happen when you fire up a grill that hasn't been used for several months. **Inspect It!**

Gas Grill Safety Tips (Propane)

Propane Grill Do's

- Ensure lid is up when lighting grill!
- Turn burner controls off and keep the cylinder valve closed when not in use.
- Be sure to store cylinders outdoors and away from sources of ignition.
- Before lighting a gas grill, check all connections for tightness.
- If there is a significant and uncontrollable release of gas or fire, call the fire department immediately and move all people and pets away from the unit.

Propane Grill Don'ts

- Do not light grill when lid is closed!
- Do not leave the cylinder in a vehicle.
- Do not use matches or lighters to check for leaks.
- Do not allow children to tamper or play with the cylinder or grill.
- Do not use, store, or transport a cylinder where it could be exposed to high temperatures. (This includes storing spare cylinders under or near the grill.)

Prepare to Extinguish

Extinguishers for Class A fires (i.e., ordinary combustible materials such as paper, wood, cardboard, and most plastics) must be located no more than 75 feet from hazard.

Extinguishers for Class B fires (flammable or combustible liquids such as gasoline, propane, kerosene, grease and oil) must be located no more than 50 feet from hazard.

Extinguishers for Class C hazards (fires involving electrical equipment, such as appliances, wiring, circuit breakers and outlets) must be located 50 to 75 feet from hazard.

Application of extinguishers (fire extinguishers must be aimed at the base of the fire during application).

NOTE: Never use water to extinguish a Class C - Electrical Fire, 'shock hazard' or a Class B fire (flammable or combustible liquids such as gasoline, propane, kerosene, grease and oil) fire spreads as fuel floats on the water.

Lightning Detection – Prepare for the Storm

Little League International Lighting Plan

WSLL Lightning and Thunder Policy

Managers and coaches should ensure their players gather all gear and prepare to evacuate the fields due to threatening weather and/or lightning

Play (or practices) will immediately be suspended when any of the following are observed by any League Official:

- Lightning is observed
- Lightning detector indicates lightning within 10 miles or less. Lightning detector takes precedence over observed weather to suspend play and vacate
- Thunder is heard suspend & vacate

In suspension - fields will be cleared of all players, managers/coaches, umpires, and spectators. Everyone moves to a vehicle for a minimum of 30 minutes.

In suspension (exception) - within hard shelter equipment shed or concession stand at Byron or Burke, Gray Hat Officials and Umpire could gather inside to evaluate conditions. All other spaces will be closed and remain closed upon/during suspension of play.

If lightning/thunder is observed or the detector indicates lightning again then play is suspended for another 30 minutes from the subsequent observance.

Games will be cancelled if the suspension will result in delay more than 45 minutes.

- When a game (or practice) is suspended on one field, it is suspended on all local fields.

Know the basic facts about lightning and its dangers

- All thunderstorms produce lightning and are dangerous. In an average year, lightning kills more people in the U.S. than tornadoes or hurricanes.
- Lightning often strikes outside the area of heavy rain and may strike as far as 10 miles from any rainfall. Many deaths from lightning occur ahead of storms because people wait too long before seeking shelter or after storms because people return outside too soon...**If you hear thunder, you are in danger.**

Lightning Safety: **Make It Part of Your Game Plan!**

**Author: Andy Kula, Senior Meteorologist
National Weather Service**

When thunderstorms threaten, coaches and sports officials must not let the desire to start or complete an athletic activity hinder their judgment when the safety of participants and spectators is in jeopardy. Each year in the United States, more than 400 people are struck by lightning. On average, about 70 people are killed and many others suffer permanent neurological disabilities. Most of these tragedies can be avoided if proper precautions are taken.

Lightning Risk Reduction Outdoors



When Thunder Roars, Go Indoors!

The lightning safety community reminds you there is little you can do to substantially reduce your risk if you are outside in a thunderstorm. The only completely safe action is to get inside a safe building or vehicle.

National Lightning Safety Institute lists six steps to safe outdoor events

- 1. A responsible person should be designated to monitor weather conditions.** Local weather forecasts should be monitored 24 hours prior to events. A portable weather radio is recommended.
- 2. Suspension and resumption of activities should be planned in advance.** Safe evacuation sites include metal vehicles with windows up, enclosed buildings, or if necessary, low ground.
- 3. Unsafe shelter areas include all outdoor metallic objects like flag poles, fences, light poles, and metal bleachers.** *Avoid* trees, water, open fields, and using the telephone.
- 4. Lightning's distance from you can be referenced by noting the time from its flash to the bang of associated thunder.** For each five second count, lightning is one mile away, i.e. 10 seconds = 2 miles. Since the distance from one strike to the next can be up to 1.5 miles, the NLSI suggests you activate your lightning evacuation plan *no later* than a count of 15.
- 5. If you feel your hair standing on end or hear "crackling noises," you are in lightning's electric field.** Immediately remove metal objects and objects with metal pieces like baseball caps, place your feet together, duck your head, and crouch like a catcher with hands on knees.
- 6. People struck by lightning do not carry an electrical charge and are safe to handle.** Apply CPR immediately if qualified, and get emergency help.

Why are enclosed buildings with substantial wiring and plumbing safe to be inside?

If lightning should directly strike a building with electricity or plumbing, the dangerous electrical current from the flash will typically travel through the wiring or plumbing, and then into the ground. This is why you should stay away from corded devices and water; baths, sinks, hot tubs, and electronic equipment you are directly connected to such as corded telephones and computers.

Lightning can damage or destroy electronics so it's important to have a proper lightning protection system connected to your electronic equipment.

West Springfield Little League advocates that each Manager and Coach get the Weather Bug App on their iPhone or Android, and use Washington Irving MS, Springfield, Virginia, as their reporting station.

PREVENT PREVENTABLE INJURY

Physical Fitness, Conditioning, and Safe Game Fundamentals

The physical well-being of players who are accepted in the Little League program is essential to avoid the hazards of unsafe personal conditions.

It is strongly suggested that all candidates for the Little League program pass a basic physical examination before playing. Another important way physical checkups are used to prevent accidents is by requiring a medical release after a player has recovered from an accident and prior to playing ball.

Warm-Up Drills – Stretching and Conditioning

This important phase of Little League training has a direct bearing on developing a safe personal condition. Extensive studies on the effect of conditioning, commonly known as “warm-up,” have demonstrated that:

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

These warm-up skills are most effective when the motions are patterned after natural baseball movements such as reaching for a ball, running and similar footwork. This is also a good place to “drive home” the basic safeguard of keeping the eye on the ball.

The subject of warming up before a practice session or game is being covered as a means of safeguarding youngsters, at least to a degree, from poor physical condition and lack of limbering up.

Overuse Injury – Proper Curveball – Dangers to the Catcher

- Link 1 ‘Pitchers Elbow’,

http://www.littleleague.org/Assets/forms_pubs/asap/LearnTeachDangersOverUse.pdf

- Link 2 ‘Curveball & Catchers’,

http://www.littleleague.org/Assets/forms_pubs/asap/CurveballsCatchersFatigue.pdf

Little League International supplied us with two brochures written by *Michele Smith*, Olympic Gold Medalist pitcher for the USA Softball Team. She has a B.S. in Health Wellness, Movement Sciences and Pre-Med at Oklahoma State University.

Click here to access:

Michele Smith (Conditioning) -

http://www.littleleague.org/Assets/forms_pubs/asap/Michele_Smith_conditioning.pdf or

http://www.littleleague.org/Assets/forms_pubs/asap/Michele_Smith_stretching.pdf

Controls are Essential

Having set the stage for our Little League safety program, let's look at the control of unsafe conditions. It is a logical step because accidents caused by unsafe conditions can be controlled more readily than those involving a human element.

Responsibility

The League President has the primary responsibility for safe conditions. However, it is not possible to cover all details personally, so most of this responsibility is delegated to others. The following delegations are in-place:

1. Safe maintenance of fixed ball field property, including structures - the head groundskeepers
2. Procurement and upkeep of practice and playing equipment, particularly personal protective equipment, the equipment manager
3. Each manager should see that the field in-use and playing equipment does not create hazards
4. The umpire should take the initiative to insure unsafe conditions are corrected on the playing field and in foul territory during games.
5. The responsibility for maintaining safe conditions for the entire league falls on the shoulders of the president. Many other important safety jobs are delegated to the Safety Officer most suited to handle them, as follows:
 - (a) The safety of players and adults going to and from fields is very important as shown by the severity of traffic accidents. See section on Traffic Safety.
 - (b) The first aid kit must be kept properly equipped and arrangements for emergencies up to date. See section on First Aid.
 - (c) Taking measures to counteract hazards that may be connected with special events such as picnics, fund-raising projects, etc.
 - (d) The safety of spectators, including parking facilities.
 - (e) The safe handling of food and drinks at the concession stand.
 - (f) If the league operates under artificial lights, the league has the very important responsibility for making sure the lights meet minimum requirements. This is a must for safe conditions. Light meter checks should be made at regular intervals to find out when it is necessary to clean reflectors and replace partly worn light bulbs.

Exposure to Unsafe Practices

Unsafe acts are far more difficult to control than hazardous conditions because they involve the unpredictable human element and surprise. ***It has been estimated that unsafe acts account for 80% of all accidents.*** Assuming every effort has been made to provide safe conditions, we should look at players' exposure to unsafe acts. Finding the causes is not enough—definite steps must be taken to counteract such acts.

Existing Safeguards

Before looking at these accident exposures and some suggestions for their control, let's look at some of the built-in safety factors in our favor.

1. It is obvious that non-contact sports such as baseball and track produce far fewer accidental injuries than contact sports like football and hockey.
2. Little League has proven the value of its playing rules and equipment requirements by the fact that each season less than 2 in 100 players have accidents resulting in injuries requiring outside medical treatment.

This is far better than the average accident frequency of 6 accidents per 100 participants in school baseball programs for the same age group.

3. Furthermore, 9 and 10-year-old Little League children have fewer accidents than the 11 and 12-year-olds.

There are probably a number of factors that account for this difference, such as:

- (a) The ball is neither batted nor thrown as hard by younger players as by older ones.
- (b) Nine and ten-year-olds do not put in as much time actually playing ball as the older players.
- (c) Younger players are less easily disabled by bumps and falls than their older teammates.

With proper instruction and drill, it is expected that younger players will develop protective skills that will see them through the more competitive age levels of the game. It must be kept in mind too that some younger players will develop faster and be better able to handle themselves than some 11 and 12-year-olds. ***EXCEPTIONS ARE VERY FEW.***

Don't rush your child to play at higher levels than they are truly ready for. Use your 'parental' hat and say no. Kids have plenty of time to grow. Why rush it?

Bottom-Line: Baseball at all levels (like any other sport) has dangers. The only path toward mitigating these risks flows straight through each manager and coach 'to the players' in the form of proper preparation and education. **There is no such thing as avoiding the unexpected. Know it could happen and plan for it.**

Safeguards

Attitude - Alertness - Hustle - Enthusiasm (Good Sportsmanship)

1. An attitude of alertness, hustle and enthusiasm is highly recommended as a guideline in this safety program, and should be carried down to all players to spark them in the development of better skills
2. Good sportsmanship and courtesy, which are necessary for a harmonious and safe environment, can be taught best through good examples set by all adults on and off the field.
3. Your most effective tool to inspire an attitude of self-confidence and a desire to excel is the use of much PRAISE and RECOGNITION. Of course, this must be given when deserved so as not to be cheapened by too much repetition. After all, a really good try rewarded by a word of encouragement may be a good play on the next attempt.
4. 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.

Again, it is emphasized that good training is most effective weapon against accidents caused by unsafe acts.

Unsafe Activities

Warm-Up Drills

Use of the term “warm-up drills,” in connection with unsafe acts, refers to ball handling practice rather than calisthenics. This involves a serious accident exposure to misdirected balls. The following will reduce the danger of being struck by a misdirected ball:

1. All unauthorized people should remain off the field during drills.
2. After the number of targets has been reduced to minimum, one of the best preventive measures is to stress “the eye must be kept on the ball”. This safe practice should be drilled into both adults and youngsters so continuously that it becomes a reflex action.
3. Another danger from misdirected balls is the exposure of inexperienced batters to wild pitchers. The use of batter’s helmets is a must. However, it does not justify permitting a potential pitcher throwing to an inexperienced batter until control is demonstrated.
4. The danger of being struck by a ball can be further minimized by the following:
 - (a) Throwing and catching drills should be set up with players in two facing lines.
 - (b) Random throwing should be permitted only to designated players.

Safe Ball Handling

1. Misjudging the flight of a batted ball may be corrected by drilling with fly’s which begin easy and made more difficult as a player’s judgment and skill improves. Everyone should eventually be able to handle balls that go overhead.
2. 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.
3. 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. Also, if moving forward, the player is in a better position to make a throw.
4. It is safer for the player to knock a ball down and recover than to let the ball determine the play.
5. Batting – WSLI has adopted a fake bunt rule to state that, “If a batter shows as to bunt, then re-tracks and swings at the pitched ball, the batter is out.”

Collisions

Collisions result in more injuries than is the case with most other types of accidents. They are usually caused by errors of judgment or lack of teamwork between fielders. It is important to establish zones of defense to avoid collisions between players. It is particularly important when players are chasing high fly balls. Once the zones are established, play situation drills should be held until these zones and patterns become familiar to the players. The responsible player should call out the intentions in a loud voice to warn others away. Here are some general rules to follow:

1. The fielder at third base should catch all balls which are reachable and are hit between third and the catcher.
2. The fielder at first base should catch all balls reachable which are hit between second and the catcher.
3. The shortstop should call all balls reachable which are hit behind third base.
4. The fielder at second base should catch all balls reachable which are hit behind first base.
5. 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.
6. The centerfielder has the right of way in the outfield and should catch all balls which are reachable. Another player should take the ball if it is seen that it is not reachable by the centerfielder.
7. Outfielders should have priority over infielders for fly balls hit between them.
8. Priorities are not so easy to establish on ground balls, but most managers expect their base player to field all ground balls they can reach, cutting in front of the shortstop on slow hit grounders.
9. The catcher is expected to field all topped and bunted balls which can be reached except when there is a force play or squeeze play at home plate.

Warning Track

In addition to collisions between players, occasionally a player chasing a fly ball will crash into the fence. These accidents also can be controlled by suitable drill work. In this case it is simply a matter of giving the outfielders an opportunity to practice getting the feel of the warning track under their feet.

They must learn to judge their distance from the fence and the probable point where the ball will come down. It would be worse than futile to not only miss catching the ball by a wide margin but also be injured by a collision with the fence.

Keep Grounds Clear

Another duty that should be given in turn to substitute players is the picking up of bats and proper placement in the rack. The clearing up of other loose playing equipment should be included in this assignment.

Sliding Safety

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

TEACH THE DANGERS!



As is the case with other baseball fundamentals, a correct slide is also a safe one. It is well advised to guard against the accident of a collision and the possibility of a player being struck by a thrown ball as that player “hits the dirt.” It goes without saying that steel spikes are not being worn. The following can make the learning period safer:

1. Long grass has been found to be better than a sand or sawdust pit to teach sliding.
2. The base must not be anchored down.

3. Sliding pads are recommended.
4. The player should make approaches at half speed and keep constantly in mind that 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.
5. Tennis shoes are suggested for beginner sliding and tagging practice to avoid injury to the defensive player.
6. If the ground along the baselines becomes soft on a rainy day, such weather offers an excellent opportunity to have sliding drills.
7. It should be kept in mind that head-first sliding* is not allowed 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. Again, the best defense is an alert, confident concentration on the ball. This type of injury is more prevalent in Regular than in Minor League play. Since the danger is increased as pitchers learn to throw with greater force and as more games are played, it is doubly important to take whatever countermeasures necessary to offset this exposure. Other sports use face shields ... I guess we don't need them!

1. A well-fitted, NOCSAE approved helmet is the first requirement.
2. 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 delivery until it lands in the catcher's mitt. Players with slow reflexes can also be helped by stimulated batting and ducking practice with a tennis ball.
3. The unsportsmanlike practice of crowding the plate or jumping around to rattle the pitcher must not be tolerated. This could endanger the batter if it causes the pitcher to lose control. Umpires should stop such actions.
4. 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. This should be corrected.
5. When the batter becomes a base runner, that player should be taught to run outside the foul lines when going from home plate to first and from third to home, to reduce the chance of being hit by a thrown ball.

Safe Handling of Bats

A review of the batter's potential for causing injuries to others points up the following:

1. 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:
 - (a) Having the player hand the bat to the coach will serve as a reminder before each ball is pitched.

- (b) Having the player drop the bat in a marked-off circle near where running starts.
- (c) Counting the player “out” in practice whenever the player fails to drop the bat correctly.
- (d) Ensure bat grips are not slippery.

2. Coaches and umpires should be on the alert to correct batters that have a tendency to step into the catcher as they swing.

A Dangerous Weapon

We use this heading to note the seriousness of an accident exposure that may sound impossible but one which has caused several very serious accidents on several occasions. The preceding precautions apply to the actions of individuals who should have control over the bat they are using.

A more serious injury is waiting for the absent-minded youngster who unconsciously walks into the swing of the coach’s bat when the coach is hitting flies, or the equally unwary player who walks into the swing of a player in the on-deck circle*. These situations demonstrate the need for everyone to become safety-minded, not only for their own good but also for the safety of others. The following precautions are suggested:

1. The player assigned to catching balls for the coach hitting flies should be given the specific assignment of warning away anyone who comes too close.
2. All players and adults should be trained to walk around the on-deck circle* whether it is in use or not. The ingrained safety habit of keeping clear may save someone a painful injury.

Catcher Safety

1. ***The catcher has more accidents/injuries than any other player.*** Statistics show the severity of injuries is less in Majors level play than in Minor League play. Again, 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:

- (a) Keep it relaxed.
- (b) Always have the back of the throwing hand toward the pitcher when in position to catch.
- (c) Hold all fingers in a cupped position near the mitt, ready to trap the ball and throw it.

2. The catcher should also be taught to throw the mask and catcher’s helmet in the direction opposite the approach in going for a high fly.
3. 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 as one foot farther from the batter than the ends of the outstretched fingers.
4. To repeat, the best protection is keeping the eye on the ball.



General Inattention

Going one step back to the “whys” of most ball handling accidents, it appears that inattention due to inaction or boredom is an underlying accident cause with which we must deal. This situation can be partly offset by using idle time to practice basics of skillful and safe play, such as:

1. Otherwise idle fielders should be encouraged to “talk it up.” Plenty of chatter encourages hustle and enthusiasm.
2. Players waiting for a game or practice to start can pair off and play catch to improve their basic eye-on-the ball technique.
3. Practice should include plenty of variety in the drill work.
4. Put a time limit on each drill and do not hold the total practice for more than two hours, if interest begins to lag.
5. Idle players along the sidelines 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 and sliding.

Safety Inspections – Fields and Equipment

Regular safety inspection of the field, permanent and temporary structures, ball playing equipment and personal protective equipment is the best way to determine which unsafe conditions require correction. The managers and grounds keepers should work together to insure serious accident exposures are corrected promptly!

The following list will be of assistance in determining conditions that cause accidents. ***Prompt action must be taken on all serious hazards.***

Some examples are:

1. Unsafe field conditions such as holes, ditches, rough or uneven spots, slippery areas and long grass.
2. Foreign objects like stones, broken glass, old boards, pop bottles, rakes, etc.
3. Incomplete or defective screen, including holes, sharp edges and loose edges.
4. Wire or link fencing (and protective tops) should be checked regularly for similar defects which could injure a participant.
5. Board fences should be free of protruding nails, loose boards, and splintered wood.
6. Forty (40) feet in the center section of the outfield fence should be painted a dark color and kept free of signs to provide a contrast with balls thrown toward home.
7. The warning track should be well defined and not less than 10 feet wide.
8. The backstop should be padded and painted green for the safety of the catcher.
9. The dugout should be clean and free of debris.
10. Dugouts and bleachers should be free of protruding nails and wood slivers.



THE AMERICAN NATIONAL GAME OF BASE BALL
ORIGINATED BY THE YACHTSMEN OF NEW YORK, 1846

11. Home plate, batter's box, bases (disengage-able) and the area around the pitcher's rubber should be checked periodically for tripping and stumbling hazards.
12. Material used to mark the field should be a nonirritating white pigment (not lime). White plastic marking tape has proved better and less expensive than other methods of marking.
13. Loose equipment such as bats, gloves, masks, balls, helmets, etc., must be kept off the ground and floor of the dugout.
14. Constant attention must be given by managers, coaches and umpires to the possible lack or poor fit of personal protective equipment. This would include helmets, masks, catcher's pads and safe shoes. ***Plastic cup supporters are required for regular and reserve male catchers and are highly recommended for all male players in the field of play.***
15. Personal jewelry, badges, pencils, etc., can be a hazard to the wearer and should not be permitted.
16. Corrective glasses should be of the sports type and equipped with "industrial" safety lenses. Most children's glasses come with safety lenses as a standard.
17. Shatterproof, flip-type sun glasses are good protection against losing a fly ball in the sun.
18. Bats should be inspected for orderly storage, secure grips and freedom from cracks. Cracked, broken or distorted bats should never be used.
19. Safety should be the major factor when making a decision on canceling a practice or game because of bad weather or darkness.
20. The greatest hazard in connection with weather conditions is exposure to lightning. At the first indication of such a storm; everyone should leave the playing field and seek shelter.
CHANCES OF SURVIVING BEING STRUCK BY LIGHTNING ARE SO SLIGHT THAT MANAGERS AND UMPIRES MUST NOT TAKE CHANCES ON CONTINUING A PRACTICE OR GAME WHEN AN ELECTRICAL STORM IS APPROACHING
21. The correct fitting and spruce appearance of uniforms has the indirect benefit of contributing to pride and morale, which stimulates our main safety objective of greater skill for fewer accidents.



Hazards in Travel to and from the Field

Travel Hazards

Although Little League traffic accidents involve only one or two cases for every hundred injuries from all accidents, the average severity of these accidents far exceeds those from other causes.

In Little League we have not only an opportunity but an obligation to take organized action for the protection of our own interests. Let's do something about it together.

General Accident Prevention

First, let's look at what can be done to implant the basic principles of traffic safety in the thinking of our adults and particularly our players.

Possible Preventative Measures

1. The most positive approach, and probably the most effective, is appealing to their loyalty to the Little League uniform or cap. Parents, managers and coaches should impress upon them that their behavior along the way will give other people a good or bad impression of Little League, depending on how they act.

2. Youngsters should also feel the restraining effect of orders to go directly to the field and report to their manager or coach. The same order should apply to going straight home and checking-in with their parents.

3. As an indirect precaution, parents should be encouraged to have their youngsters learn how to swim. This is particularly important if there are any bodies of water within striking distance of their route. This knowledge may save their lives when temptation is stronger than the voice of authority.

4. A surprising number of accidents also occur when youngsters reach the vicinity of the field but it is not yet time for practice or a game. In this situation it is the direct responsibility of any adults who are nearby to stop such activities as climbing trees, chasing each other, running up and down the grandstands, etc.

5. Volunteers should make local authorities aware of potential risks in the area; unfenced excavation or quarries and lakes with unsecured boats...



WHEN INJURY STRIKES

What you should do – What needs to happen – How to Report an Incident and what Parents need to know about LL Insurance

The physical well-being of players who are accepted in the Little League program is essential to avoid the hazards of unsafe personal conditions.

It is strongly suggested that all candidates for the Little League program pass a basic physical examination before playing. Another important way that physical checkups are required is by obtaining a medical release prior to a player returning from an accident.

Defining Terms

To clarify the meaning of these guidelines, we are defining terms used by Little League Baseball to describe and report in our accident-prevention program.

They are as follows:

1. ACCIDENT is a sudden, undesirable and unplanned occurrence often resulting in bodily injury, disability and/or property damage.
2. ACCIDENT CAUSE is an unsafe condition, situation or act that may result directly in or contribute to the occurrence of an accident.
3. CORRECTIVE ACTION is the positive steps or measures taken to eliminate, or at least minimize, an accident cause.
4. CASE is used in the general sense, such as: accident case, injury case, etc...
5. HAZARD refers to a condition or a situation that could cause an accident.
6. INJURY is the physical harm or damage often resulting from an accident.
7. INSURANCE CLAIM refers to the right of a parent, as in the case of accident insurance to have eligible medical expenses resulting from an accidental injury connected with a game or scheduled practice paid by the appropriate insurance.
8. TYPE OF ACCIDENT is a phrase used to describe an unintentional, sudden incident that can be identified so effective counter measures may be taken. Examples are: struck by, tripped, fell, collided with, caught between, etc.

9. AN UNSAFE ACT refers to unintentional human failure or lack of skill that can lead to an accident. It is one of the two general accident causes, the other being an unsafe condition.

10. AN UNSAFE CONDITION is an abnormal or faulty situation or condition which may cause an accident. Its presence, particularly when an unsafe act is committed, may result in an accident.

Accident Reporting Procedures

CALL 911 – Any injury that causes a player to lose consciousness, or visibly broken bone, call 911.



What to Report

Any incident that causes a player, manager, coach, umpire, or volunteer to receive medical treatment and/or first aid must be reported to the league safety officer within 48 hours of the incident. This includes even passive treatments such as the evaluation and diagnosis of the extent of the injury or periods of rest that results.

When to Report

All such incidents described above must be reported to the Safety Officer within 48 hours of the incident. The Safety Officer is **Ken Nehilla**: 703-455-3389. The best method is via email; kneh617036@aol.com or phone. This phone supports message handling, email, call waiting and voice-mail.

WHY Make a Report

Accident Tracking serves two purposes. (1) It's used to document injuries, track insurance claims and the recovery period. (2) It's also used by our league to track all incidents – those requiring medical attention and those not requiring medical attention. Little League calls these 'Close Calls'. Doing this tracking will help our league determine if additional training is needed for specifics like sliding (if several players in a division are hurting their legs or ankles, but not enough to go to the hospital); or if players are getting hurt on a specific field from bad hops, the field may need dragging or other work, etc. It's just another mechanism to help pin-point problems before someone needs medical attention or first-aid treatment.

How to Make the Report

Reporting incidents should be done by a manager/coach or parent filling out the Accident Reporting Form and sends it to the league Safety Officer. The Safety Officer may complete the necessary form, and then follow up to verify all information.

At a minimum, the following information must be given:

- Name and phone number of the person injured or involved in the incident
- Date, time, and location of the incident

- Provide as detailed a description of the incident as possible
- Preliminary estimation of the extent of any injuries
- Name and phone number of the person reporting the incident

Safety Officer's Responsibilities

Within 48 hours of receiving an incident report, the Safety Officer will contact the injured party through Parents and/or Team Manager to:

- (1) Verify the information received;
- (2) Obtain additional information if necessary;
- (3) Check on the status of the injured party; and
- (4) In the event the injured party requires other medical treatment (i.e., Emergency Room visit, doctor's visit, etc.) will advise the parent or guardian of Little League's insurance coverage and the provisions for submitting any claims.

If the extent of the injuries is more than minor in nature, the Safety Officer shall periodically call the injured party to:

- (1) Check on the status of any injuries, and
- (2) to check if any other assistance is necessary in areas such as submission of insurance forms, etc. until such time as the incident is considered "closed" (i.e., no further claims are expected and the individual is participating in league activities).

Accident Notification Form (Simple Example)

Please give a detailed description of incident:

Could this accident have been avoided? Explain How:

This form is for Little League purposes only, to report safety hazards, unsafe practices and/or to contribute positive ideas in order to improve league safety.

When an accident occurs, obtain as much information as possible.

Making use of Accident Reporting

In the effort to prevent accidents to Little Leaguers one must deal with the unpredictable actions of many small athletes. One of the most widely accepted ways to counteract unsafe acts, which are so often a part of uncertain behavior is to inquire into the reasons behind such acts and take suitable countermeasures.

Since we cannot eliminate all of these disturbing and sometimes tragic mishaps, one must use them as tools to help control similar or related accidents.

Which Accidents to Analyze

Good judgment must be used in deciding which accidents to analyze. The severity of an injury should not be the only basis of deciding to determine reasons for an accident and what can be done to reduce the chances of its reoccurrence. The possibility of a similar and more severe accident occurring should be our main reason for getting at the causes and taking suitable corrective action.

Examples of cases that probably would not require detailed checking would be a “raspberry” from sliding or minor strains and bruises, not associated with serious unsafe acts or conditions.

Further Follow-Up on Accident

Even after corrective measures have been put into effect, responsible adults should continue to check back to make sure unsafe habits have not been resumed and conditions are not allowed to slip. We advise youngsters to keep their eye on the ball. Let’s do the same with safety precautions.

FIRST AID

First aid is an important part of any safety program. Like insurance coverage, it is a form of protection that must be available in case of an emergency involving any injury. At least one coach or manager from each team must attend first aid training annually.

Definition: First aid is the immediate, necessary, and temporary, emergency care given for injuries.

First Aid Equipment

Since this document is not intended as a First Aid Manual, we will cover only immediate care for injuries that may be experienced during baseball events. The proper equipping of first aid kits will be left to the advice of local medical authorities. In addition to the stock of bandages and cleaners, the following should be available:

1. A supply of clean water, soap and clean towels
2. blanket for preventing shock
3. Arm and leg splints
4. Easily accessible phone with emergency phone numbers, hospital and ambulance service.

Notification of Family

It is extremely important that, as soon as provision has been made for the care of the injured or ill people who require outside treatment, family be notified in as tactful a manner as possible.

Follow-Up on First Aid Cases

Care of an ill or injured individual must always be the first consideration. In concern for their welfare, however, do not neglect the following:

1. A thorough investigation should be made to find the cause(s) of an accident, and action started to prevent recurrence.
2. An insurance claim should be filed when outside medical attention is required. Do not wait for medical bills to arrive. They can be submitted as they become available. They must be identified by including the person’s name, league name and number, date of injury, and city and state of residence. Bills should be itemized to show dates and type of treatments.
3. Any player under the care of a doctor would be required to bring a note from the doctor to the Team Manager releasing the player to resume play.



You're in Charge and there's an Injury – What Now!

Remember '**RICE**' as a quick guide for impact injuries

- **Rest, Ice, Compression, Elevation**

The role in an emergency situation for Managers and Coaches is to:

- Stop all play to protect the player from further injury – as well as those not being closely monitored due to the focus being on the injured player.
- Check player's Breathing, Pulse and Alertness to immediately judge the seriousness of the injury:
 - If necessary, send someone to call 911 to get an ambulance or EMS help immediately.
 - Call the player's parents (or ask another adult standing near-by).
 - Send an adult to nearest intersection to direct emergency services.
 - Review the Medical Release form for important information/warnings about medical conditions the player may have.
- Evaluate the injury:
 - Can player be moved off field?
 - If 'NO' – clear area around player and begin examination;
 - If 'YES' – move the player to sideline and make as comfortable as possible while attending to the injury;
 - Determine if the player can return to play or needs first aid.

Give the appropriate First Aid for the injury

Coaches and Managers should understand the specific techniques to determine whether injuries are **mild, moderate** or **severe**, and should understand how to address each type. The evaluation includes classifying injuries using symptoms and signs, with appropriate looking, listening and careful feeling and, if appropriate, moving of the injured part.

In evaluating fresh injuries, remember there are three types of motion:

- **Active Motion** – Player is able to move the injured part themselves
- **Active Assistive Motion** – Player is able to move with a little help from you; watch for warning signs like the player telling you it hurts to move
- **Passive Motion** – the player's injured part can only be moved by someone else; be especially cautious to not make the injury worse

Look for disability (the player can't use injured part); this is the most serious injury. If a player sprains his ankle, but can still limp around, it may be mild or moderate; if he can't get up, it is probably severe. Look for swelling, the more immediate and large the swelling, the more serious the injury, because swelling on outside means bleeding on inside. Also, a noticeable deformity means a serious injury. If the body part doesn't look the way it did before the accident, get help.

Consider unconsciousness or any eye injury as a serious situation, in the category of severe injuries, until you are assured otherwise by a medical professional.

"I would vote for using a little common sense on this one" – get help!

And remember, **if in doubt to the nature or seriousness of an injury**, you should NOT attempt treatment; a health care professional should be consulted immediately. **Make the call!** ((CALL 911))

1. Administer the appropriate First-Aid
2. Turn over care to professionals when they arrive and help as directed.
3. If parents are not available, go with player to treatment center in ambulance; turn the team over to an authorized coach.
4. **Do not forget to carry the player's medical release with you (to all events).** You need to have each players form with you at all official gatherings.
5. If emergency medical treatment isn't immediately required, urge player and parents to see a doctor for a proper diagnosis and treatment plan.
6. Record the injury on an injury report. Your Safety Officer will provide all assistance needed.
7. Follow up with the player (and parents) until injury is healed and player can return to play.
8. Get medical release prior to allowing a player to return for practice or game play when formal treatment was required.



Summary: How to Prevent Injuries:

1. Health screenings collected at signup through a health questionnaire/ medical release form asking for health concerns and medications
2. Proper maintenance of playing site (game and practice facilities)
3. Pay close attention to playing conditions (heat and humidity as well as severe weather)
4. Make sure players know basics of good nutrition (especially water replacement on hot and high humidity days)
5. Proper athletic conditioning (stretching, strengthening and endurance, as well as agility and coordination drills)
6. Avoid over use (pay special attention to activities outside of Little League, to allow rest to avoid over-use injuries)
7. Consistent and proper use of all protective baseball equipment
8. Close coach supervision and organization of warm-ups, practices and games
9. Careful compliance with all Little League rules, especially those having to do with safety



It's important to remember we need to carefully evaluate all injuries and ensure the child does not require professional care.

**** **It's not worth risking a child's health just to continue a game.**

Cardiopulmonary Resuscitation (CPR)

Heart disease is the number 1 killer in the United States. Each year, almost 330,000 Americans die from heart disease. Half of these will die suddenly, outside of the hospital, because their heart stops beating.

The most common cause of death from a heart attack in adults is a disturbance in the electrical rhythm of the heart called ventricular fibrillation.

Ventricular fibrillation can be treated, but it requires applying an electrical shock to the chest called defibrillation.

***If a defibrillator is not readily available,
brain death will occur in less than 10 minutes.***

To buy time until a defibrillator arrives - provide artificial breathing and circulation by performing cardiopulmonary resuscitation (CPR).

The earlier you give CPR to a person in cardiopulmonary arrest (no breathing, no heartbeat), the greater the chance of a successful resuscitation.

By performing CPR, you keep oxygenated blood flowing to the heart and brain until a defibrillator becomes available.

Because up to 80% of all cardiac arrests occur in the home, you are most likely to perform CPR on a family member or loved one.

CPR is one link in what the American Heart Association calls the "chain of survival." The chain of survival is a series of actions that; when performed in sequence, will give a person having a heart attack the greatest chance of survival.

When an emergency situation is recognized, the first link in the chain of survival is early access. This means activating the emergency medical services, or EMS, system by calling 911.

The next link in the chain of survival is to perform CPR until a defibrillator becomes available.

In some areas of the country, simple, computerized defibrillators, known as automated external defibrillators, or AEDs, may be available for use by the lay public or first person on the scene. If available, early defibrillation becomes the next link in the chain of survival.

Once the EMS unit arrives, the next link in the chain of survival is early advanced life support care. This involves administering medications, using special breathing devices, and providing additional defibrillation shocks if needed.



NOTE: This reference is only intended to serve as a guideline for learning about CPR. It is not intended to be a replacement for a formal CPR course. If you are interested in taking a CPR course, contact the [American Heart Association](#) at (800) AHA-USA1, or the [American Red Cross](#) by phoning your local chapter. Never practice CPR on another person, because bodily damage can occur.

Learn CPR for a loved one or friend.

Cardiac Arrest

When a person develops cardiac arrest, the heart stops beating. Without a pulse, no blood flowing to the brain, the person becomes unresponsive and stops breathing normally.

When you discover a person whom you believe is experiencing a medical emergency, check for responsiveness. Gently shake the victim and shout, "Are you OK?"



Check the victim for a pulse

#ADAM.

If the person does not respond to your voice or touch, they are unresponsive. If the victim is unresponsive and you are alone, leave the victim and immediately call 911. If someone is with you, tell them to call 911 and return to help the victim.

If an AED is available, bring it back to the person's side. The moment an AED becomes available, IMMEDIATELY press the "on" button. The AED will begin to speak to you. Follow its directions to use the AED.

Rescue Breathing

You now need to check to see if the person is breathing normally.

You do this by first opening the person's airway. Tilt the victim's head back by lifting the chin gently with one hand, while pushing down on the forehead with the other hand.

Next, place your ear next to the victim's mouth and nose and listen, look, and feel: Look to see if the chest is rising, listen for any sounds of breathing, and feel for any air movement on your cheek.

Taking no more than 5-10 seconds, if you do not see, hear, or feel normal signs of breathing, you must breathe for the victim.

While keeping the victim's head tilted back, place your mouth around the victim's mouth and pinch the victim's nose shut. Give 2 slow breaths, making sure the person's chest rises with each breath.



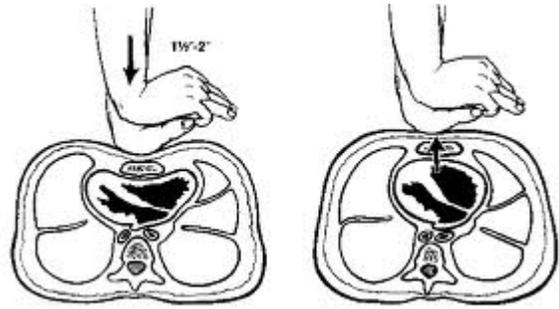
Chest Compressions

After giving 2 breaths immediately begin chest compressions.

Place the heel of one hand on the center of the chest, right between the nipples. Place the heel of your other hand on top of the first hand. Lock your elbows and position your shoulders directly above your hands. Press down on the chest with enough force to move the breastbone down about 2 inches.

Compress the chest 30 times, at a rate slightly faster than once every second.

After 30 compressions, stop, open the airway again, and provide the next 2 slow breaths. Then, position your hands in the same spot as before and perform another 30 chest compressions. Continue the cycles of 30 compressions and 2 breaths until an AED becomes available or until EMS providers arrive.



CPR in Children

Sudden cardiac arrest is less common in children than it is in adults. It usually happens when there is a lack of oxygen caused by a breathing problem such as choking, near-drowning, or respiratory infections. Because oxygen often corrects the problem in a child, when an unresponsive, non-breathing child is found, CPR is performed for 1 minute before activating the EMS system. This may reverse the lack of oxygen and revive the child.

In order to use an AED on a child from one year of age through eight years of age a special pediatric cable is used to reduce the amount of energy provided by the electrical shock.

Doing CPR on children aged one year to eight years is similar to doing CPR on adults. However, there are some minor differences. Most are due to the child's smaller size.

When compressing the chest, the heel of only 1 hand is used instead of 2 hands, and the chest is pressed down about $\frac{1}{2}$ of its depth.

Perform 5 cycles of 30 chest compressions followed by 2 breaths, and then use an AED to evaluate the heart rhythm if available... If an AED is not available, and the child is still not breathing normally, coughing, or moving, continue cycles of 30 compressions to 2 breaths until help arrives.



TYPES OF INJURIES (EDUCATION)

Not trying to turn baseball managers and coaches into medical experts. However, we need to make quick evaluation of injuries.

The goal is to give each team as much knowledge as practical toward dealing with injuries. These types of injuries have occurred and will occur again while playing youth sports. We've covered prevention, reaction and now taking action to assist a fallen member of our community. It could be a young player, a middle aged volunteer, or a grandparent who came to our park to

Starting with basic terminology (contusion, laceration, etc.) then moving toward a greater understanding of the appropriate first-aid techniques for injuries most likely to be encountered with baseball. Under each injury the most up-to-date assessment, treatment and prevention for such sports injuries will be listed.

Muscle Contusions

Overview - Any blunt trauma with sufficient force to propel its energy into the muscle can cause a contusion.

Diagnosing

Symptoms of a contusion are often nonspecific and the diagnosis is one of exclusion. Contusion symptoms include soreness and pain with active range of motion (AROM), passive range of motion (PROM), as well as limited range of motion (ROM). Presentation of a contusion is characterized by direct trauma to the muscle group with subsequent pain and swelling resulting from bleeding within the muscle.

A contusion usually can be distinguished from a muscle rupture, because residual function remains after a contusion. Muscle ruptures are usually straightforward; sudden intense pain, tightness, and loss of function occur. The patient usually describes a popping sensation. Muscle strains are differentiated by the history of high stress use as opposed to the history of a direct trauma as with a contusion.

Distinguishing a contusion from delayed-onset muscle soreness can be difficult in patients with delayed presentation, particularly if the patient is unsure if direct trauma caused the injury (such as in football when multiple traumatic events happen simultaneously). One helpful distinction is that delayed-onset muscle soreness tends to develop well after the

sporting event, or even the next morning, and tends to be distributed symmetrically if muscle groups are used in tandem.

Ask the patient if he/she has a family history of bleeding disorders or easy or frequent bleeding or bruising.

A final, yet vital consideration is the possibility of physical abuse. An inconsistent history provided by the patient and family is the hallmark of child abuse (see Further Reading).

Treatment

Muscle contusion indicates a direct, blunt, compressive force to a muscle. Contusions are one of the most common sports-related injuries. The severity of contusions ranges from simple skin contusions to muscle and bone contusions to internal organ contusions. Although tissue and organ contusions can result from traumatic sports injury, this article focuses on muscle contusions only.

The goal of therapy is to minimize hemorrhage and inflammation and to control pain. Limb immobilization with rest, ice, compression, and elevation (RICE) should be performed for the first 24 hours in patients with minor contusions and for 48 hours in patients with moderate or severe contusions.

The general recommendation is to avoid heat during the first 24-48 hours to avoid increasing the extent of hemorrhage and edema. Once the bruise has stabilized, heat may help break up the mass of blood and tissue; however, this practice has been shown to be of limited benefit.

The use of crutches should be emphasized for patients with thigh contusions, as weight bearing following a thigh contusion injury may be extremely painful and may extend the damage. The knee joint should be flexed to pain tolerance in conjunction with the compression dressing. Compression gently increases tension, limiting the extent of the intramuscular hematoma. In addition, the position of flexion stretches the muscle, which increases tension and also facilitates drainage of the edematous fluid from the region.

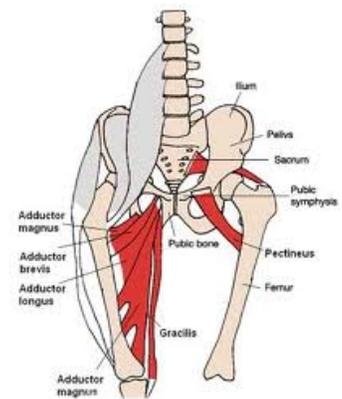
Muscle Strain (i.e. Hamstring or other)

Muscle strain or muscle pull or even a muscle tear implies damage to a muscle or its attaching tendons. You can put undue pressure on muscles during the course of normal daily activities, with sudden, quick heavy lifting, or during sports.

Muscle damage can be in the form of tearing (part or all) of the muscle fibers and the tendons attached to the muscle. The tearing of the muscle can also damage small blood vessels, causing local bleeding (bruising) and pain (caused by irritation of the nerve endings in the area).

Diagnosing

Swelling, bruising or redness, or open cuts as a consequence of the injury, Pain at rest, Pain when the specific muscle or the joint in relation to that muscle is used, Weakness of the muscle or tendons (A sprain, in contrast, is an injury to a joint and its ligaments.), Inability to use the muscle at all.



When to Seek Medical Care

If you have a significant muscle injury (or if the home care methods bring no relief in 24 hours), call your doctor.

If you hear a "popping" sound with the injury, cannot walk, or there is significant swelling, pain, fever, or open cuts, you should be examined by a physician.

Treatment

The amount of swelling or local bleeding into the muscle (from torn blood vessels) can best be managed early by applying ice packs and maintaining the strained muscle in a stretched position. Heat can be applied when the swelling has lessened. However, the early application of heat can increase swelling and pain.

***Note:** Ice or heat should not be applied to bare skin. Always use a protective covering such as a towel between the ice or heat and the skin.*

Take anti-inflammatory agents such as aspirin and ibuprofen to reduce the pain and to improve your ability to move around.

Rest, Ice, Compression, and Elevation (known as the RICE formula) can help the affected muscle.

Rest the strained muscle. Avoid activities that caused the strain and other activities that are painful.

Ice the muscle area (20 minutes every hour while awake). Ice is a very effective anti-inflammatory and pain-relieving agent. Small ice packs, such as packages of frozen vegetables or water frozen in foam coffee cups, applied to the area may help decrease inflammation.

Compression can be gently applied with an Ace or other elastic bandage, which can provide both support and decrease swelling. Do not wrap tightly.

Elevate the injured area to decrease swelling.

Activities that increase muscle pain or working the affected body part are not recommended until the pain has significantly gone away.

Tendinitis (Overuse Injury)

Overview - Tendons are cords of tough, fibrous connective tissue that attach muscles to bones. Tendinitis is an inflammation of the tendon. The condition may also involve the tendon sheath, usually close to where the tendon joins the muscle. Tendinitis is also informally spelled tendonitis.

Tendons are generally healthy structures that appear glistening white to the naked eye. If you've ever carved a turkey, the tendons are the tough bands you cut through to get the drumsticks apart.

Tendinitis Causes - The most common cause of tendinitis is overuse and repetitive motion from recreational, athletic, or occupational activities. Risk factors for tendonitis include repetitive movement, trauma, thermal injury to the tendon, use of certain antibiotics (such as levofloxacin and ciprofloxacin), and smoking. Tendinitis can also occur in people with diseases such as rheumatoid arthritis, obesity, and diabetes.

These are some of the more common forms of Tendinitis:

Medial epicondylitis (golfer's elbow, *baseball elbow*) is caused by inflammation of the tendons that attach to the medial epicondyle of the elbow. If you put your arms to your side with the palms facing forward, the medial epicondyle is the bony part of the elbow nearest to your body. Repetitive movements involving forceful wrist flexion and rotation can cause this elbow tendinitis.

Lateral epicondylitis (tennis elbow) is caused by inflammation of the tendons that attach to the lateral epicondyle of the elbow. If you put your arms to your side with the palms facing forward, the lateral epicondyle is the bony part of the elbow farthest away from your body. Repetitive movements involving extension and rotation of the wrist can cause this elbow tendinitis.

Rotator cuff tendinitis (swimmer's shoulder, tennis shoulder, pitcher's shoulder) is caused by sports that require movement of the arm over the head repeatedly. This repetitive motion causes inflammation on the rotator cuff, a group of muscles that control shoulder rotation. The supraspinatus, infraspinatus, teres minor, and subscapularis tendons form the rotator cuff tendons.

Bicipital tendinitis is inflammation of the tendon that attaches the biceps muscle (located in the front of the arm) to the shoulder. Wear and tear over time or overuse are common causes of bicipital tendinitis.

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Patellar tendinitis (jumper's knee) is inflammation of the patellar tendon that attaches the kneecap to the tibia. Patellar tendinitis is caused by repetitive jumping, running, or cutting movements.

Peroneal tendinitis is inflammation of the tendon that is located in the side of the ankle and foot. Excessive hiking, tennis, or other activities may cause this.

Tendinitis Symptoms and Signs

Tendinitis causes pain over the affected tendon. The pain is usually worsened with repetitive motion, but it can also be present at rest. There can also be mild swelling over the tendon.

When to Seek Medical Care

If you have symptoms of tendinitis, see your doctor to rule out other causes of pain.

Diagnosis

Diagnosis is usually made based on the way the affected tendon and movement of the associated muscle feels. The doctor may have you do the following movements to check for pain and tenderness.

Medial epicondylitis: The forearm is placed in supine position (with the palm facing upward), and the fist is flexed against resistance while the forearm is held down. Tenderness is felt on the inner side of the elbow where the bony medial epicondyle is located.

Lateral epicondylitis: The forearm is placed in prone position (with the palm facing downward) on the table, while the forearm is held in place. You try to extend your wrist



against resistance. Tenderness is felt along the top of the outer elbow near the bony lateral epicondyle.

Supraspinatus: Bend the arm to 90° and place it forward 30° with the thumb pointed down. Pain or weakness against resistance can be felt if there is involvement of this tendon.

Infraspinatus and teres minor: With your arm against your body with elbow bent at 90°, the doctor will stabilize the elbow against your waist and have you externally rotate (move your arm outward) against resistance, which will bring on pain if these tendons are involved.

Subscapularis: With your arm against your body and the elbow bent at 90°, while stabilizing the elbow, the doctor will have you internally rotate your arm inward around the front of your body against resistance, which will cause pain if this tendon is involved.

Patellar tendinitis: Tenderness can be felt over the patellar tendon at the lower part of the kneecap.

Peroneal tendonitis: Tenderness is felt when the peroneal tendon (located on the side of the ankle) is palpated.

Treatment

Ice the affected area 20 minutes at a time every several hours for at least the first 24-48 hours. Wrap ice in a towel to protect your skin. Your

Elevate and immobilize the affected extremity while resting

Use of over-the-counter anti-inflammatory medications (such as Advil or Aleve)

Use slings and splints to keep the injured area of shoulders and arms from moving.

Prevention

Use proper technique during sports or occupational activities.

Warm up and decrease overuse and repetitive motion of associated muscles.

Stop physical or occupational activity if there is any sign of pain.

Broken or Knocked-out Teeth

The 20 primary or baby teeth are replaced, beginning at about 6 years, with 32 adult or permanent teeth. Injury to teeth, especially permanent teeth, can be painful and serious.

Broken or Knocked-Out Teeth Causes

Dental injuries to the teeth commonly occur with falls, assaults, sports activities, child abuse, and multiple traumas such as an auto collision.

Broken or Knocked-Out Teeth Symptoms

Toothache and jaw pain are common symptoms of dental injuries. Some people may complain of pain with chewing or with temperature changes.

Although a tooth may have broken off, loosened, fallen out, or been pushed into the gum line, other less common symptoms may be seen.

Isolated bleeding from the mouth; Cuts surrounding the lips and cheeks; Facial swelling; A change in the tooth's color (may take a long time to appear)

When to Seek Medical Care

If you have a concern about a possible tooth injury or change in tooth color, call your dentist or doctor. Often when teeth are knocked out, however, you need to seek emergency care, especially if the tooth is a permanent one.

Seek emergency dental or medical care in the following instances:

Trouble breathing, Persistent bleeding (won't stop), Severe pain, Facial swelling

Exams and Tests

If there is no other trauma, the doctor or dentist will take a history of events leading up to the injury. A focused examination of the face, neck, mouth, and the teeth follows. The doctor or dentist will look for damage to the jaw, salivary ducts, and nerves, as well as to account for all missing teeth.

For a single tooth injury, a plain dental x-ray will be taken, although most hospitals do not offer this type of film. A panoramic x-ray may also be taken to detect dental injuries. This image is taken as the device sweeps around the jaw in an arc and permits a thorough structural evaluation of the teeth, jaw, and soft tissue structures. It is typically found in most oral surgeons' offices, as well as in some dental offices and some Emergency Departments.

If a tooth is missing and is suspected to have been swallowed, an x-ray may be taken to try to find it. The tooth may end up in the throat, lung, or stomach.

The Ellis classification is a way to grade or describe tooth fractures. The higher the number, the more serious the fracture.

An Ellis I fracture solely involves the enamel. This is the proverbial "chipped tooth." It is usually painless and more a cosmetic problem than anything else.

An Ellis II fracture extends through the enamel and stops at the dentin. Usually the tooth is sensitive to cold.

In an Ellis III fracture, the injury extends through all 3 layers, exposing the pulp causing extreme pain, often accompanied with mild bleeding from the tooth itself.

Broken or Knocked-Out Teeth Treatment

Before focusing on the teeth, be certain that a life-or-limb threatening injury is not present. For example, if someone fell 10 feet and is not responding, and there is a puddle of blood by the mouth with teeth scattered about, don't assume there is an isolated injury to the teeth. In the grand scheme, dental injuries can wait.

If a tooth is completely knocked out, it should be quickly rinsed off with water, but never scrubbed. The tooth should be held by the crown (top), not the root, so you do not damage the ligaments. In a cooperative adult, the tooth should be put back in the socket.

Many people may be uncomfortable re-implanting the tooth on their own. If this is the case, be sure to transport the tooth to the doctor or dentist in saline, milk, or saliva.

You may also place the tooth between the cheek and gum line of either the person who lost the tooth or any willing adult. The mouth is the best place for the tooth because it protects the root by keeping it moist and providing protection against bacteria.

Do not transport the tooth dry. This will cause damage within minutes. Transporting the tooth in water is also not recommended.

In children or uncooperative adults, the tooth ideally should be placed in a "tooth saver" solution, which can be provided by your health care professional. Effective substitutes include saline, milk, or saliva. An uncooperative adult or child may swallow the tooth. Of greater concern, the person may inhale it, causing a choking episode.

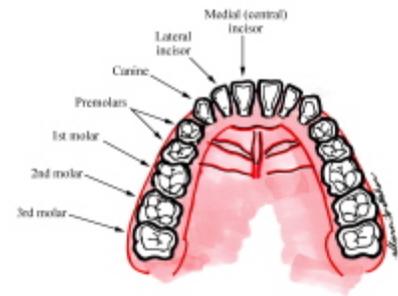
If bleeding from the socket is seen, rinse the mouth out with water. Place a wad of tissue or gauze on the socket and bite down on it. The pressure exerted will usually stop the bleeding.

For loosened, pushed in, or broken teeth, avoid eating or drinking anything. If the tooth is broken in pieces, retrieve any remaining parts and transport them in one of the suggested solutions.

Medical Treatment

For teeth that are just loose in their socket, treatment is simple. Avoid hard foods. Teeth with significant motion will need to be stabilized using wire, metal arch bars, or a plastic bond for 10-14 days.

For knocked out permanent teeth, the sooner the tooth is put back in its socket, the better its chances. The best chance for survival occurs if the tooth is re-implanted within 30 minutes. Once implanted, the tooth must be stabilized using the techniques just described for 2-4 weeks.



Broken teeth are managed according to their Ellis classification. For a minor chip (Ellis I), no acute treatment is necessary. You might need mild pain medication for comfort. This injury typically needs a cosmetic repair that can be completed by a dentist.

For the more significant tooth fractures (Ellis II and III), certain steps are employed to reduce infection, control pain, and reduce the chance of permanent damage to the pulp.

In Ellis II fractures, the exposed dentin is covered with calcium hydroxide, which provides a protective covering for nerves and blood vessels.

An Ellis III injury (where the pulp is exposed) will need continued dental care. A pulpectomy may need to be performed. Immediate bonding is another option.

For adult teeth that are pushed into the gum line, no acute treatment is necessary if the tooth is stable and not likely to fall out. An x-ray will be needed to look for a fracture in or near the socket. In most cases, the tooth will push itself back out, returning to its normal position. The only exception occurs with a primary (baby) tooth. If it injures the developing adult tooth below it, permanent damage may occur, resulting in cosmetic disfigurement or loss of the permanent tooth.

In general, any time a tooth is struck, microscopic nerve or blood vessel damage may occur, even without apparent initial injury. The damage may show as a color change over a period of days to months and lead to the death of the tooth.

Prevention - People seldom plan to fall and injure their teeth. Therefore, there is little to offer in the way of prevention other than keeping the environment clear of debris. However, for people engaged in sports, it is wise to use a mouth guard. These rubber devices are

inexpensive and could prevent serious dental injury. You can buy them at most sporting goods stores or ask your dentist to fit you with one.

Outlook - For knocked-out primary (or baby) teeth, there are frequently no long-term problems unless the permanent tooth was damaged. Sometimes the remaining baby teeth drift together and narrow the space for the new adult tooth.

With adult teeth, the sooner the tooth is re-implanted, the better its chance of survival. Once an adult tooth is lost, it can never be replaced.

For broken teeth, the more superficial the injury, the better the outcome. Once the nerve or blood supply is compromised, the worse the final result.

Pushed-in teeth typically erupt on their own, if there is no underlying damage to bone, nerve, blood supply, or the developing adult tooth.



Facial Fracture

A fracture is a broken bone. Facial fracture refers to any injury resulting in a broken bone or bones of the face.

Facial Fracture Causes

Many situations can cause facial fractures. Motor vehicle crashes, sporting injuries, falls, and assault account for the majority.

Always be concerned about other injuries with facial fractures. In particular, other parts of the body may be injured, for example, if you have facial injuries in a motor vehicle accident.

Facial Fracture Symptoms

Although certain symptoms are specific for the bone fractured, some symptoms are common to any fractured bone. But remember that these symptoms may indicate a soft tissue injury (without a broken bone); Pain, Swelling, Bruising

Broken nose Symptoms

Swelling, Tenderness, Deformity, Nosebleed (if present, is usually minor)

Significant trauma to the bridge of the nose may result in a fracture of the bones inside your nose (ethmoid bones).

These bones, if fractured, may cause the brain to connect with the outside environment. Possible symptoms include persistent nosebleed or a clear nasal discharge.

Broken jaw / Symptoms

Jaw pain, Tenderness, Inability to bring the teeth together properly (malocclusion), Bruising under the tongue almost always indicates a jaw fracture.

Midface (maxillary) fracture / Symptoms (if conscious) - Inability to bring the teeth together properly, visual problems, Clear nasal discharge, Bruising may be present around the eyes and the midface may be able to be moved. These fractures are not usually subtle and are often the result of high-speed car accidents. As a result, there might be severe injury to areas other than the face. Many of these people will have difficulty breathing and require a tube to be placed down their throat to help them breathe.

Cheekbone (zygomatic) fracture / Symptoms -

Flatness of the cheek, altered sensation underneath the eye on the affected side, Visual complaints, Pain with jaw movement, Blood in the side of the eye on the affected side sometimes is present.

Eye socket (orbital) fracture / Symptoms - Sunken eye (enophthalmos), altered sensation beneath the affected eye, double vision, particularly with upward gaze. This fracture involves the bones of the eye socket. Injury usually occurs when a blunt object hits the eye such as a fist or a ball.

Temporomandibular joint (TMJ) dislocation / Symptoms - Jaw deviation, inability to close the mouth, dislocation of the TMJ (the joint where your jaw meets with the temporal bone, right in front of your ear) can occur with blunt trauma, seizures, or excessive mouth opening.

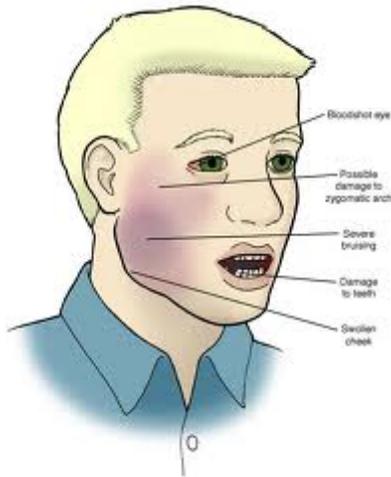
When to Seek Medical Care

A doctor should check any significant facial injury. You can either see your doctor or go to the emergency department.

A doctor should check all people with facial trauma. In the event of massive trauma, 911 should be called.

If you experience the following symptoms, evaluation by a doctor is important:

Clear nasal discharge, Nosebleed, Loss of consciousness, Any visual disturbance such as double or blurry vision, Any hearing problem, Inability to bring teeth together, Pain with jaw movement, Altered sensation on the face, Face uneven (asymmetrical), Open wounds with visible bone.



Facial Fracture Treatment

Home care is limited until a doctor sees you. Use an ice pack on the area to help with pain and swelling. Apply direct pressure to bleeding areas.

Medical Treatment

Nasal fracture - First, the doctor will control your nosebleed (if you have one). If there is a collection of blood inside your nose, called a septal hematoma, the doctor will drain it by cutting a hole in it to let the blood out.

Because your nose will be very swollen at first, a broken nose is not immediately put back into place (reduced).

Even after the swelling goes down, reducing a broken nose is necessary only if you will have a poor cosmetic result or your airflow is obstructed. If it is necessary, a specialist will do it at a follow-up appointment. By this time, the swelling should have gone down, and the bone should be put in place more accurately.

Bones fractured inside your nose (ethmoid fractures) requires hospitalization.

Jaw (mandibular) fracture - A broken bone that is visible through the skin or inside the mouth, called an open fracture, requires hospital admission and IV antibiotics.

Midface (maxillary) fracture - Because of the severity of a midface fracture and its associated injuries, you may require a tube to be inserted to help you breathe, and you will most likely be hospitalized.

Cheekbone (zygomatic) fracture: If your zygomatic arch is fractured, you may require surgery to repair it if the fracture is pushed in causing a cosmetic defect.

Eye socket (orbital) fracture - The timing of and need for eye socket fracture repair is controversial. Seek medical advice.

Temporomandibular joint dislocation: This is usually realigned in the emergency department using a local anesthetic and medication to relax the jaw.

Eye Injuries

Eye injuries range from the very minor, such as getting soap in your eye, to the catastrophic, resulting in permanent loss of vision.

Eye Injuries Causes

Corneal abrasions: The cornea can be thought of as special, transparent skin that covers the eye. A corneal abrasion is, in effect, a scratch or an abrasion of that specialized skin. People with corneal abrasions often report that they were "poked" in the eye.

Traumatic iritis: This type of injury can occur in the same way as a corneal abrasion. It is also associated with a blow to the eye from a blunt object, such as a fist or a club. The iris is the colored part of the eye. It is actually a muscle that controls the amount of light that enters the eye through the pupil. Iritis simply means that the iris is inflamed.

Hyphemas and Orbital Blowout fractures: These injuries are associated with significant force from a blunt object to the eye and surrounding structures. Examples would be getting hit in the face with a baseball or getting kicked in the face.

Hyphemas are the result of bleeding in the eye that occurs in the front part of the eye, called the anterior chamber. This is the space between the cornea and the iris.

An orbital blowout fractures are cracking or breaks of the facial bones surrounding the eye.

Lacerations (cuts) to the eyelids and the conjunctiva (mucous membranes): These injuries commonly occur from sharp objects but can also occur from blunt force trauma.

Lacerations to the cornea and the sclera: These injuries are very serious and are frequently associated with blunt trauma of flying objects.

Foreign bodies in the eye: Generally, a foreign body is a small piece of metal, wood, or plastic filing. It could be anything that gets into the eye.

Ultraviolet keratitis (or corneal flash burn): The most common light-induced trauma to the eye is ultraviolet keratitis, which can be thought of as a sunburn to the cornea. Sources of damaging ultraviolet light are arc welders, tanning booths, and the sun.

Eye Injuries Symptoms

Chemical exposure: The most common symptoms are pain or burning. The eye may become red, and the eyelids may become swollen.

Subconjunctival hemorrhage (bleeding): Generally, this condition is painless. Vision is not affected. The eye will have a red spot of blood on the sclera (the white part of the eye). This

occurs when there is a rupture of a small blood vessel on the surface of the eye. The area of redness may be fairly large, and its appearance is sometimes alarming. It is not dangerous and generally goes away slowly with no treatment.

Corneal abrasions: Symptoms include pain, a sensation that something is in the eye, tearing, and sensitivity to light.

Iritis: Pain and light sensitivity are common. The pain may be described as a deep ache. Sometimes, excessive tearing is seen.

Hyphema: Pain and blurred vision are the main symptoms.

Orbital blowout fracture: Symptoms include pain, especially with movement of the eyes; double vision that disappears when one eye is covered; and eyelid swelling after nose blowing. Swelling around the eye and bruising often occur.

Conjunctival lacerations: Symptoms include pain, redness, and a sensation that something is in the eye.

Lacerations to the cornea and the sclera: Symptoms include decreased vision and pain.

Corneal: A sensation that something is in the eye, tearing, blurred vision, and light sensitivity are all common symptoms. Sometimes, the foreign body can be seen on the cornea. If the foreign body is metal, a rust ring or stain can occur.

Intraorbital: Symptoms, such as decreased vision, pain, and double vision, usually develop hours to days after the injury. Sometimes, no symptoms develop.

Intraocular: You may have eye pain and decreased vision, but, initially, you may have no symptoms.

Ultraviolet keratitis: Symptoms include pain, light sensitivity, redness, and a feeling that something is in the eye.

Solar retinopathy: Decreased vision is the primary symptom.

When to Seek Medical Care

In most cases, if you have continuing symptoms of pain, visual disturbance, or bleeding, you should go to an ophthalmologist (a medical doctor who specializes in eye care and surgery).

In general, if you are not sure if you have a serious eye injury, call your ophthalmologist for advice.

Lacerations: Cuts that affect the eyelid margins (where the eyelashes are) or the eyeball itself need immediate medical attention.

Solar retinopathy: Evaluation by an ophthalmologist is necessary. This is one condition where there is little that can be done in the emergency department.

Questions to Ask the Doctor

Is there any sign of damage to the eye? Is there sign of permanent vision loss?



Eye Injuries Treatment

How to wash out your eye

How it is done is less important than getting it done with great amounts of water. A water fountain makes a great eye wash. Just lean over the fountain, turn on the water, and keep your eye open. At a sink, stand over the sink, cup your hands, and put your face into the running water.

If you are near a shower, get in and put your eye under the running water. This is a good option if you have been sprayed with a chemical in the face and hair.

Hold a glass of water to your eye and tip your head back. Do this many times.

If you are working outside, a garden hose running at a very modest flow will work.

Subconjunctival hemorrhage: Minimal treatment is needed. Avoid further trauma to the eye, such as rubbing. This injury will heal with time.

Corneal abrasions: Little can be done at home for corneal abrasions. People who wear contact lenses should avoid using their lenses until evaluated by an ophthalmologist. You should seek medical care promptly.

Traumatic iritis: Some people become very light sensitive, and sunglasses may help until treatment is begun.

Hyphema: Keep your head elevated. Do not lie flat. Keep quiet with minimal activity until you are seen by an ophthalmologist. Do not take aspirin for any pain, because this will increase the risk of bleeding. You should seek medical care promptly.

Orbital blowout fractures: Keep your head elevated, and apply ice to your face to reduce swelling. Do not take aspirin for any pain, because this will increase the risk of bleeding.

Lid lacerations: You should seek immediate medical care. Do not attempt to put anything directly on the eyeball. Do not take aspirin for any pain, because this will increase the risk of bleeding.

Lacerations to the eyeball: Protect your eye, and do not put any pressure on your eye. You should seek immediate medical attention.

Foreign bodies: Gentle flushing with water will often dislodge foreign bodies that have not embedded themselves in the cornea. Do not try to rub or wipe off foreign bodies with a tissue, a Q-Tip, or anything else. Doing so will usually not remove an embedded foreign object and will result in a corneal abrasion that may be more painful than the foreign body itself. Intraocular and intra-orbital foreign bodies cannot be treated at home.

Medical Treatment

Orbital blowout fractures: Ice and elevation of the head for 48 hours are recommended to reduce swelling. You are advised not to blow your nose. Some ophthalmologists use nasal decongestants and



oral antibiotics for 1-2 weeks. If any surgical repair is needed, it is usually done 1-2 weeks later when the swelling has gone down.

Prevention

Most eye injuries can be prevented with protective or safety glasses.

Wear safety glasses whenever you operate power tools, such as drills, saws, or power washers; when using a hammer; or when mixing or spraying chemicals.

Welder's goggles or face masks should be used when using an arc welder. A common scenario for ultraviolet keratitis in welders is that the welder lights his or her torch with the welder's mask up and then flips it down after the torch is lit.

Eye coverings should be used in tanning booths, but it is best to completely avoid tanning, indoors and out.

Do not rub your eye.

Never look directly into the sun. When outdoors on bright, sunny days, wear good quality sunglasses. This will reduce the amount of ultraviolet exposure to your eyes. This is particularly important when there is significant reflective glare, such as at the beach, on the water, or in snow-covered areas.

Heat Cramps

Heat cramps are painful, brief muscle cramps that occur during exercise or work in a hot environment. Muscles may spasm or jerk involuntarily. Cramping may also be delayed and occur later.

Heat cramps usually involve the muscles fatigued by heavy work such as calves, thighs, abdomen, and shoulders.

You most at risk doing work or activities in a hot environment-usually during the first few days of an activity you're not used to.

You are also at risk if you sweat a great deal during exercise and don't drink enough or drink large amounts of fluids that lack salt.

Heat Cramps Causes

The exact cause of heat cramps is unknown, but it is probably related to electrolyte problems. Various essential minerals, such as sodium, potassium, calcium, and magnesium, are known as electrolytes. They are important for many body functions, and an electrolyte imbalance can cause problems.

Sweat contains a large amount of sodium, and drinking fluids with inadequate sodium content after sweating profusely may result in a serious low-sodium condition called hyponatremia. Some factories have virtually eliminated heat cramps in their workers by supplying salt-enriched fluids.

Heat Cramps Symptoms

Muscle spasms - Painful, Involuntary, Brief, Intermittent, away on their own)

When to Seek Medical Care

Heat cramps can be quite painful. Consider seeking medical attention if the symptoms do not go away with rest and after restoring fluid.

Call your doctor if these conditions develop:

If you are unable to drink sufficient fluids because you have nausea or vomiting, you may need IV rehydration with normal saline.

If you have more severe symptoms of heat illness, including dizziness, fatigue, vomiting, headache, malaise, shortness of breath, and high temperatures (greater than 104°F) - seek medical care.

If you have more severe forms of heat illness or think you require IV fluids to rehydrate, seek care at a hospital's emergency department.

Heat Cramps Treatment

Heat cramps usually go away whether you do anything or not.

Rest in a cool place and drink fluid mixed with salt.

Make your own salt solution by mixing 1/4 to 1/2 teaspoon table salt dissolved in a quart of water.

Commercially available electrolyte beverages and sports beverages such as Gatorade will provide adequate dietary salt intake.

Salt tablets by themselves should not be used. They can cause stomach upset and don't adequately replace fluid volume lost.

Prevention - If you work in a hot environment, you may experience heat cramps during the first few days of that work. Once you get used to the environment, and you have adequate salt-fluid replacement, you should have no further problems.

Outlook - Heat-induced muscle spasms usually go away on their own.

Insect Bites

Stings and bites from insects are common. They often result in redness and swelling. Sometimes a sting can cause a life-threatening allergic reaction.

The orders that contain the greatest numbers of species are Coleoptera (beetles), Lepidoptera (butterflies and moths), Hymenoptera (ants, bees, wasps), and Diptera (true flies).

Insect Bite Causes

Insects do not usually attack unless they are provoked. Most bites and stings are defensive. The insects sting to protect their hives or nests.

When a bee stings, it loses the entire injection apparatus (stinger) and actually dies in the process. A wasp can inflict multiple stings because it does not lose its injection apparatus after it stings.

Fire ants inject their venom by using their mandibles (the biting parts of their jaw) and rotating their bodies. They may inject venom many times.

In contrast, bites from mosquitoes typically do not cause significant illnesses, unless they convey "vectors," or microorganisms that actually live within these mosquitoes. For instance,



malaria is caused by an organism that spends part of its life cycle in a particular species of mosquitoes. West Nile virus is another disease spread by a mosquito.

Other types of insects, bites, and diseases

Lice can transmit epidemic relapsing fever, caused by spirochetes.

Leishmaniasis, caused by the protozoan *Leishmania*, is carried by a sand fly.

Sleeping sickness in humans and a group of cattle diseases that are widespread in Africa, and known as nagana, are caused by protozoan trypanosomes transmitted by the bites of tsetse flies.

In unsanitary conditions, the common housefly can play an incidental role in the spread of human intestinal infections (such as typhoid and bacillary and amebic dysentery) by contamination of human food.

Tularemia can be spread by deer fly bites, the bubonic plague by fleas, and the epidemic typhus rickettsia by lice.

Various mosquitoes spread viral diseases (such as equine encephalitis; dengue and yellow fever in humans and other animals).

Ticks can transmit Lyme disease and other illnesses through their bites or stings.

Other insects such as chiggers and mites typically cause self-limited localized itchiness and swelling.

Serious bites from spiders, which are not insects, can be from the black widow or brown recluse.



Black Widow



Brown Recluse

Insect Bites Symptoms

The response to a sting or bite from insects is variable and depends on a variety of factors. Most bites and stings result in pain, swelling, redness, and itching to the affected area. The skin may be broken and become infected if the bite area is scratched. If not treated properly, these local infections may become severe and cause a condition known as cellulitis.

You may experience a severe reaction beyond the immediate area of the sting if you are allergic to the bite or sting. This is known as anaphylaxis.

A sting on the tongue may cause throat swelling and death because of airway obstruction.

Stings from large hornets or multiple (hundreds or thousands) bee stings have been rarely reported to cause muscle breakdown and kidney failure.

Bites from a fire ant typically produce a pustule, or a pimple-like sore, that is extremely itchy and painful.

When to Seek Medical Care

If you start to experience symptoms that are not just at the site of the bite or sting (and you don't have a history of severe reactions), seek medical attention.



Systemic symptoms affect the whole body and may progress to fatal anaphylactic shock.

Symptoms of a severe reaction include hives, wheezing, shortness of breath, unconsciousness, and even death within 30 minutes.

Hives are the most common systemic symptom.

They appear as irregular, raised, red blotchy areas on the skin and are very itchy. If hives are the only systemic symptom present, they are often treated at home with an antihistamine.

If the bite appears infected (redness with or without pus, warmth, fever, or a red streak that spreads toward the body), see a doctor.

If you don't know what bit you, it is important to

keep watching the area closely to be sure it does not become infected. Call your doctor if there is an open wound, which may suggest a poisonous spider bite.

People who have a history of severe reactions should go to the nearest hospital's emergency department after a bite or sting if they experience any symptoms. Those who have no history of severe reactions should also go to the emergency department if they have any of the following symptoms:

Wheezing, Shortness of breath, Chest tightness or pain, Sensation of the throat closing or difficulty speaking or swallowing, Faintness or weakness

Infection; if the wound appears infected and you are not able to reach your doctor, seek care at a hospital.

Exams and Tests

The diagnosis of a reaction to a bite or sting is usually obvious from the history. The doctor will perform a physical examination to look for effects of the bite or sting on various parts

of the body. Examination of the skin, respiratory system, cardiovascular system, and oral cavity are particularly important.

Insect Bites Treatment

Treatment depends on the type of reaction. If there is only redness and pain at the site of the bite, application of ice is adequate treatment. Clean the area with soap and water to remove contaminated particles left behind by some insects (such as mosquitoes). These particles may further contaminate the wound if not removed. Refrain from scratching because this may cause the skin to break down and an infection to form.

Treat itching with an over-the-counter antihistamine such as diphenhydramine (Benadryl) in cream or pill form. Calamine lotion also helps.

People who have a history of severe reactions to bites or stings may have been prescribed an anaphylaxis kit. The kit contains an epinephrine injector (you give yourself an injection), tourniquet, and an antihistamine.



Prevention

Some vector mosquitoes are most active in twilight periods at dawn and dusk or in the evening, so avoid outdoor activity during these periods.

Wear long-sleeved shirts, long pants, and hats to minimize the areas of exposed skin. Shirts should be tucked in.

Use insect repellents. Repellents applied to clothing, shoes, tents, mosquito nets, and other gear will enhance protection.



Seizure Emergencies

Everyone has the potential to have seizures. Some people have them frequently. Seizure disorders vary tremendously. Some people have only an occasional seizure, and other people have daily or more frequent seizures.

There are many different types of seizures. Seizure activity may range from simple blank staring to loss of consciousness with spasticity or muscle jerking.

Generally, a seizure should be considered an emergency in these situations:

- Seizures that do not stop within a few minutes.
- Prolonged confusion remains after the seizure (10-15 min).
- The person is not responsive after a seizure.
- The person has trouble breathing.
- The person is injured w/seizure.
- The seizure is a first-time seizure.
- There is a significant change in the type or character of the seizure from that person's usual seizure pattern.



Seizures Emergencies Causes

Many people have seizures for reasons that are unknown. Other people have seizures from some condition that affects normal brain functioning. These may include brain tumor, infections, fever, birth injuries, injury, or trauma.

Other problems that might affect the functioning of the brain and lead to seizures include drugs or medications, alcohol, low blood sugar, or other chemical abnormalities.

Rapidly flashing lights, high stress, or lack of sleep may induce seizures.

Seizures in children are a special category of seizures addressed differently.

Seizures Emergencies Symptoms

Common generalized seizures often begin when the person cries out or makes some sound. This may be followed by several seconds of abnormal stiffening, progressing to abnormal rhythmic jerking of the arms and legs.

The eyes are generally open, but the person is not responsive or alert.

The person may not appear to be breathing. They are, however, actually usually breathing adequately for the brief duration of the seizure. The person often breathes deeply for a while after an episode.

He or she will return to consciousness gradually over several minutes.

Incontinence, or loss of urine, is common.

Often people will be combative briefly after a generalized seizure (a seizure that involves the entire brain).

Many other seizure types exist, including isolated abnormal movements of a single limb, staring spells, or abnormal stiffening without the rhythmic jerking.

Seizures Emergencies Treatment

Cushion the head.

Loosen any tight neckwear.

Turn the person on his or her side after the convulsion ceases. This may help drain any moisture or secretions from the person's mouth.

Do not attempt to hold down or restrain.

Do not place anything in the person's mouth or try to pry the teeth apart.

Observe these items: length of seizure, type of movements, direction of any head or eye turning, amount of time to return to alertness and full consciousness.



Nosebleed (Epistaxis)

Nosebleeds (epistaxis, nose bleed) can be dramatic and frightening. Fortunately, most nosebleeds are not serious and usually can be managed at home, although sometimes medical intervention may be necessary. Nosebleeds are categorized based on where they originate, and are described as either anterior (originating from the front of the nose) or posterior (originating from the back of the nose).

Anterior nosebleeds make up more than 90% of all nosebleeds. The bleeding usually originates from a blood vessel on the nasal septum, where a network of vessels converge (Kiesselbach plexus). Anterior nosebleeds are usually easy to control, either by measures that can be performed at home or by a health care practitioner.

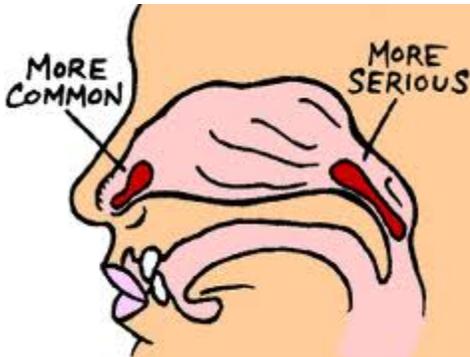
Posterior nosebleeds are much less common than anterior nosebleeds. They tend to occur more often in elderly people. The bleeding usually originates from an artery in the back part of the nose. These nosebleeds are more complicated and usually require admission to the hospital and management by an otolaryngologist (an ear, nose, and throat specialist).

One out of every seven people will develop a nosebleed at some time in their lives. Nosebleeds tend to occur more often during winter months and in dry, cold climates. They can occur at any age, but are most common in children aged 2 to 10 years and adults aged 50 to 80 years. For unknown reasons, nosebleeds most commonly occur in the morning hours.

Nosebleed Causes

Most nosebleeds do not have an easily identifiable cause. However, trauma to the nose is a very common cause of nosebleeds. Nosebleeds can be caused by trauma to the outside of the nose from a blow to the face, or trauma to the inside of the nose from nose picking. Other conditions that predispose a person to nosebleeds include: exposure to warm, dry air for prolonged periods of time, nasal and sinus infections, allergic rhinitis, nasal foreign body (object stuck in the nose), vigorous nose blowing, nasal surgery, deviated or perforated nasal septum, and cocaine use.

Less commonly, an underlying disease process or taking certain medications may cause a nosebleed or make it more difficult to control.



Inability of the blood to clot is most often due to blood-thinning medications such as warfarin (Coumadin), clopidogrel bisulfate (Plavix), nonsteroidal anti-inflammatory drugs (NSAIDs), or aspirin.

Topical nasal medications, such as corticosteroids and antihistamines, may sometimes lead to nosebleeds.

Liver disease, chronic alcohol abuse, kidney disease, platelet disorders, and inherited blood clotting disorders can also interfere with blood clotting and predispose to nosebleeds.

Vascular malformations in the nose and nasal tumors are rare causes of nosebleeds.

High blood pressure may contribute to bleeding, but is rarely the sole reason for a nosebleed. It is often the anxiety associated with the nosebleed that leads to the elevation in blood pressure.

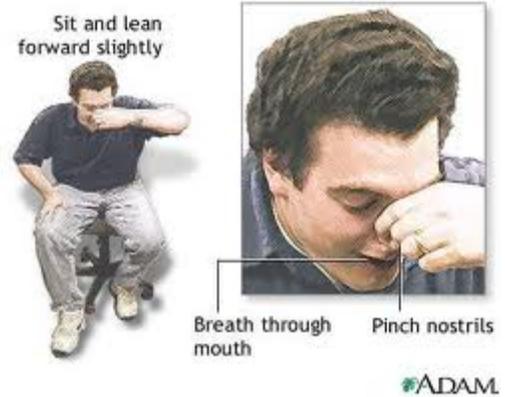
Nosebleeds in Children

Nosebleeds in children can be an anxiety-provoking event, both for the parent and the child. However, most nosebleeds in children are self-limiting and benign, and can typically be managed at home. As in adults, more than 90% of nosebleeds in children originate anteriorly.

Nosebleeds in children usually occur between 2 to 10 years of age. Nosebleeds in infants, however, are unusual and require further evaluation by a health care practitioner. Though

most nosebleeds in children are spontaneous and occur infrequently, some children may experience more frequent, recurrent nosebleeds.

The most common cause of nosebleeds in children is from minor trauma, typically from nose picking. Direct trauma to the nose, upper respiratory infections, nasal foreign bodies, allergic rhinitis, exposure to warm, dry air and nasal medications (for example, corticosteroids) are also other commonly encountered conditions leading to nosebleeds. Less common causes of nosebleeds in children include vascular malformations, leukemia, nasal tumors, and various blood clotting abnormalities. An accidental ingestion of blood-thinning medication (for example, warfarin [Coumadin]) is also a rare cause of nosebleeds in children.



The treatment for nosebleeds in children is similar to that of adults, which will be covered in a subsequent section. The prognosis in children is generally excellent, with nosebleeds caused by serious underlying medical conditions carrying a variable prognosis.

Nosebleed Symptoms

Bleeding usually occurs from only one nostril. If the bleeding is heavy enough, the blood can fill up the affected nostril and overflow into the nasopharynx (the area inside the nose where the two nostrils converge), causing simultaneous bleeding from the other nostril as well. Blood can also drip into the back of the throat or down into the stomach, causing a person to spit up or even vomit blood.

Signs of excessive blood loss include: dizziness, weakness, confusion, and fainting.

Excessive blood loss from nosebleeds does not often occur.

When to Seek Medical Care

Contact a health care practitioner if the person experiences the following: repeated episodes of nosebleeds; additional bleeding from places other than the nose, such as in the urine or stool; easy bruising; if the person has nosebleeds and is taking any blood-thinning medications (for example, aspirin or warfarin [Coumadin]); if the person has nosebleeds and any underlying disease that may affect blood clotting, such as liver disease, kidney disease, or hemophilia (inability of blood to clot); or if the person has nosebleeds and recently had chemotherapy.

Go to the hospital if the person with the nosebleed: is still bleeding after pinching the nose for 10 to 20 minutes; is having repeated episodes of nosebleeds over a short time or if a large amount of blood is lost; feels dizzy or light-headed, or feels that they are going to pass out; has a rapid heartbeat or trouble breathing; is vomiting blood; has a rash or temperature greater than 101.4 F (38.5 C); or if a health care practitioner instructs you to go to a hospital's emergency department.

Nosebleed Diagnosis

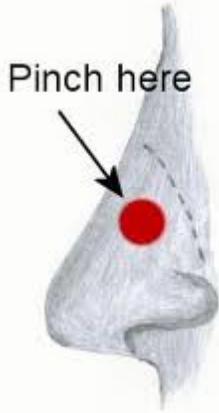
The diagnosis of a nosebleed is generally self-evident upon seeing the patient, though some individuals may not have any active bleeding by the time they arrive to seek medical care. More importantly, however, your health care practitioner will need to locate the source of bleeding and determine whether the person has an anterior or posterior nosebleed. Other

less common causes of nosebleeds may need to be sought depending upon the individual's medical history.

Nosebleed Treatment

A small amount of bleeding from a nosebleed requires little intervention. For example, if a person with a cold or a sinus infection blows his or her nose vigorously and notices some blood in the tissue, one should avoid forceful nose blowing, sneezing, and nose picking. This is usually enough to keep the bleeding from getting worse.

How to stop a nosebleed



- Remain calm.
- Sit up straight and lean slightly forward.
- Lean your head forward. Tilting your head back will only cause you to swallow the blood.
- Pinch the nostrils together and apply direct pressure with the thumb and index finger for approximately 10 minutes. Time it to make sure the nostrils are not released earlier.
- Spit out any blood in the mouth. Swallowing blood may make the affected individual vomit.

This technique will stop the majority of simple nosebleeds.

What to do after the bleeding has stopped

Once the bleeding has stopped, try to prevent any further irritation to the nose, such as sneezing, nose blowing, or straining for 24 hours.

Ice packs do not help nosebleeds.

Exposure to dry air, such as in a heated home in the winter, can contribute to the problem. Adding moisture to the air with a humidifier or vaporizer will help keep the nose from drying out and triggering more bleeding. Another option is to place a pan filled with water near a heat source, such as a radiator, which allows the water to evaporate and adds moisture to the air.

Nasal saline sprays or other lubricating ointments or gels also may be useful to promote tissue healing and keeps the nasal passages moist.

Nosebleed Prevention

Most nosebleeds occur during the winter in cold, dry climates. If a person is prone to nosebleeds, use a humidifier in the home. Petroleum jelly (Vaseline), antibiotic ointment, or a saline nasal spray also may be used to keep the nasal passages moist. Try not to pick or blow the nose too vigorously.

If the nosebleed is related to an underlying medical condition (for example, liver disease or a chronic sinus condition), follow the health care practitioner's instructions to keep these medical problems under control.

Nosebleed Prognosis

With proper treatment, the vast majority of people recover from nosebleeds with no long-term effects. A minority of patients may experience severe bleeding, which can rarely be life-threatening.

Choking

Choking is a blockage of the upper airway by food or other objects, which prevents a person from breathing effectively. Choking can cause a simple coughing fit, but complete blockage of the airway may lead to death.

Choking is a true medical emergency that requires fast, appropriate action by anyone available. Emergency medical teams may not arrive in time to save a choking person's life.

Breathing is an essential part of life. When we inhale, we breathe in a mix of nitrogen (75%), oxygen (21%), carbon dioxide, and other gases.

In the lungs, oxygen enters the bloodstream to travel to the rest of the body. Our bodies use oxygen as a fuel source to make energy from the food we eat. Carbon dioxide, a waste product, enters the bloodstream and travels back to the lungs.

When someone is choking with a completely blocked airway, no oxygen can enter the lungs. The brain is extremely sensitive to this lack of oxygen and begins to die within four to six minutes. It is during this time that first aid must take place. Irreversible brain death occurs in as little as 10 minutes.

Choking Causes

Choking is caused when a piece of food or other object gets stuck in the airway.

Any object that ends up in the airway will become stuck as the airway narrows. Many large objects get stuck just inside the trachea at the vocal cords.

In adults, choking most often occurs when food is not chewed properly. Talking or laughing while eating may cause a piece of food to "go down the wrong pipe." Normal swallowing mechanisms may be slowed if a person has been drinking alcohol or taking drugs, and if the person has certain illnesses or disease.

In older adults, risk factors for choking include advancing age, poor fitting dental work, and alcohol consumption.

In children, choking is often caused by chewing food incompletely, attempting to eat large pieces of food or too much food at one time, or eating hard candy. Children also put small objects in their mouths, which may become lodged in their throat. Nuts, pins, marbles, or coins, for example, create a choking hazard. In the United States, almost 200 children die each year from choking, most of them younger than four years of age, according to the Centers for Disease Control and Prevention. It is estimated that more than 17,500 children 14 years of age or younger are treated in U.S. emergency departments for choking episodes annually.

Choking Symptoms

If an adult is choking, you may observe the following behaviors:

- Coughing or gagging
- Hand signals and panic (sometimes pointing to the throat)
- Sudden inability to talk

- Clutching the throat: The natural response to choking is to grab the throat with one or both hands. This is the universal choking sign and a way of telling people around you that you are choking.
- Wheezing
- Passing out
- Turning blue: Cyanosis, a blue coloring to the skin, can be seen earliest around the face, lips, and fingernail beds. You may see this, but other critical choking signs would appear first.
- If an infant is choking, more attention must be paid to an infant's behavior. They cannot be taught the universal choking sign.
- Difficulty breathing
- Weak cry, weak cough, or both

When to Seek Medical Care

Choking is an emergency. It can quickly result in death if not treated promptly. Call your local emergency medical services at 911 instead of your doctor. Do not hesitate to call for emergency help if you believe a person is choking. Do not attempt to drive a choking person to a hospital emergency department.

Although it only takes one person to administer first aid to the choking victim, there are other duties to perform. As you prepare to help the choking victim always shout for help.

Have other bystanders call for 911 emergency help.

Choking is an emergency. Call 911 emergency medical services. Do not attempt to drive a choking person to a hospital emergency department.

While waiting for the ambulance, follow the steps listed in the Self-Care at Home section of this article.

If the choking episode is successfully treated at home and there is no fear that other objects may still be in

the airway, a visit to the hospital may not be necessary.

If you are alone and no one responds to your calls for help, do not leave the choking person to call 911. Begin first aid immediately.

Choking Treatment

What to do if a person starts to choke:

It is best not to do anything if the person is coughing forcefully and not turning a bluish color. Ask, "Are you choking?" If the person is able to answer you by speaking, it is a partial airway obstruction. Stay with the person and encourage him or her to cough until the obstruction is cleared.

Do not give the person anything to drink because fluids may take up space needed for the passage of air.

Someone who cannot answer by speaking and can only nod the head has a complete airway obstruction and needs emergency help.

The American Red Cross and the American Heart Association each have a recommended protocol to deal with airway obstruction. Both of these protocols are described in the following section.

The American Heart Association recommends the following:

The treatment for a choking person who begins to turn blue or stops breathing varies with the person's age. In adults and children older than one year of age, abdominal thrusts (formerly referred to as the "Heimlich maneuver") should be attempted. This is a thrust that creates an artificial cough. It may be forceful enough to clear the airway.

The quick, upward abdominal thrusts force the diaphragm upward very suddenly, making the chest cavity smaller. This has the effect of rapidly compressing the lungs and forcing air out. The rush of air out will force out whatever is causing the person to choke.

How to perform abdominal thrusts

Lean the person forward slightly and stand behind him or her. Make a fist with one hand. Put your arms around the person and grasp your fist with your other hand in the midline just below the ribs. Make a quick, hard movement inward and upward in an attempt to assist the person in coughing up the object. This maneuver should be repeated until the person is able to breathe or loses consciousness. (See diagram below.)

If the person loses consciousness gently lay him or her flat on their back on the floor. To clear the airway, kneel next to the person and put the heel of your hand against the middle of the abdomen, just below the ribs. Place your other hand on top and press inward and upward five times with both hands. If the airway clears and the person is still unresponsive, begin CPR.

If you are in doubt about what to do, and you are witnessing someone choking, call for emergency help immediately, do not delay. You may be able to successfully stop the choking before help arrives using techniques discussed here, but it is best for the choking person to be evaluated by the emergency medical team when they arrive. If something is still in the person's throat, the emergency medical team can begin care immediately and take the person to the hospital for further treatment.

3. Put your arms around the person and grasp your fist with your other hand near the top of the stomach, just below the center of the rib cage.



4. Make a quick, hard movement, inward and upward.

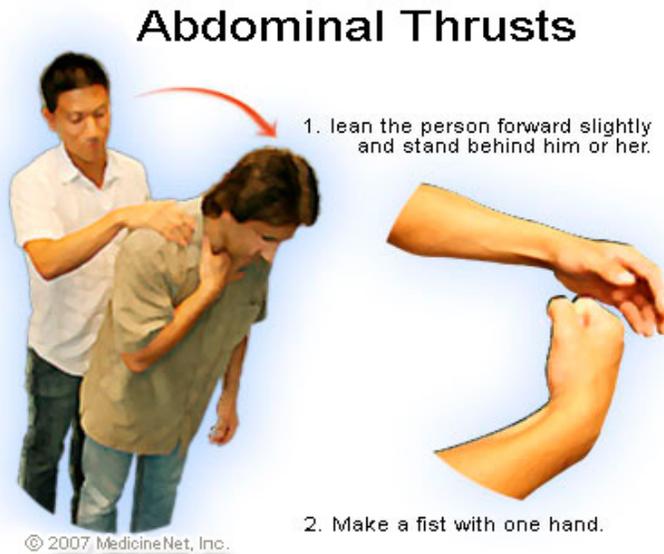


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Variations of abdominal thrusts for special circumstances:

The victim is seated: The maneuver may be performed with the victim seated. In this instance, the back of the chair acts as a support for the victim. The rescuer still wraps his or her arms around the victim and proceeds as described above. The rescuer will often have to kneel down. In the event that the back of the chair the victim is sitting in is too high, either

stand the victim up or rotate the victim 90 degrees, so that the back of the chair is now to one side of the victim.



For small rescuers and large victims, particularly children rescuing an adult: Instead of standing behind the victim, have the victim lie down on his or her back. Straddle the victim's waist. Place one hand on the belly, halfway between the belly button and the edge of the breastbone. Thrust inward and upward. This is the same technique used in

unconscious people.

You are choking and you are alone: You may deliver an abdominal thrust on yourself. This can be done in one of two ways.

You can deliver a true "self"-abdominal thrust with your own hands. This is done by positioning your hands in the same fashion as if you were performing the maneuver on another person and delivering an inward and upward thrust.

Another option is to bend your belly over a firm object, such as the back of a chair, and thrust yourself into the object.

You may pass out before you expel the object and before help arrives. In most communities, the 911 emergency system has what is known as enhanced 911. Whenever a call is placed through 911 to the dispatch center, the dispatcher has the phone number, address of the telephone, and owner of the line of the incoming call. This allows for rapid location of an incident and allows interrupted calls to be investigated.

By dialing 911 and leaving the phone line open in communities where this protocol is followed, you could be ensuring the arrival of rescue personnel in the event your "self"-abdominal thrust fails to clear the foreign body and you do pass out. If the dispatcher has no response on an open line, the call must be investigated.

Check with your local police department and find out if your 911 dispatch center follows these procedures. If you live in a community that does not have a 911 system, check with

your local police department both for the emergency number, and to find out if they follow these procedures.

Pregnant/obese people: Abdominal thrusts may not be effective in people who are in the later stages of pregnancy or who are obese. In these instances, chest thrusts can be administered. For the conscious person sitting or standing, take the following steps:

- Place your hands under the victim's armpits.
- Wrap your arms around the victim's chest.
- Place the thumb side of your fist on the middle of the breastbone.
- Grab your fist with your other hand and thrust backward. Continue this until the object is expelled or until the person becomes unconscious.

For the unconscious pregnant or obese person: The sequence of events is the same as for an unconscious adult. Chest thrusts, rather than abdominal thrusts, are delivered. To position yourself for chest thrusts, take the following steps:

- Kneel on one side of the victim.
- Slide two fingers up the bottom edge of the rib cage until you reach the bottom edge of the breastbone called the xiphoid process.
- With your two fingers on the xiphoid, place your other hand on the breastbone, just above your fingers. The thrusts should be quick and forceful to remove the object.

Care should be taken because complications such as rib fractures and heart muscle damage have been known to occur with chest thrusts.

If at all possible, subdiaphragmatic (below the ribcage) abdominal thrusts should be used in the pregnant woman, especially if there is still room between the enlarging uterus and baby, and the rib cage to perform the maneuver.

The American Red Cross recommends the following for conscious choking adult:

- Have someone call 9-1-1.
- Obtain consent from the victim.
- Lean the person forward and give 5 back blows with the heel of hand.
- Give 5 quick, upward abdominal thrusts.
- (NOTE: You can give yourself abdominal thrusts by using your hands, just as you would do to another person, or lean over and press your abdomen against any firm object such as the back of a chair.)
- Continue alternating back blows and abdominal thrusts until:
- The obstructing object is forced out.
- The person can breathe or cough forcefully.
- The person becomes unconscious.

What to do next: If the victim becomes unconscious, call 9-1-1, if not already done, and follow the steps for an unconscious choking adult below.

American Red Cross recommends the following for an unconscious adult:

Try 2 rescue breaths. (If available, use protective barrier airway, resuscitation mask or face shield. The American Red Cross recommends that rescue breaths should not be delayed because you do not have a barrier or do not know how to use one).

To give a rescue breath:

- Tilt the head and lift the chin, then pinch the nose shut.
- Take a breath and make a complete seal over the person's mouth.
- Blow in to make the chest clearly rise.
- (TIP: Each rescue breath should last about 1 second.)
- If breaths do not go in, tilt the head farther back. Try 2 breaths again.
- If the chest does not rise - give 30 chest compressions. (TIP: Remove breathing barrier when giving chest compressions.)

To give a chest compression:

- Place two hands in center of the chest (on lower half of sternum).
- Compress 1-1/2 to 2 inches.
- Compress 30 times in about 18 seconds (100 compressions per minute).
- Look for an object in the airway.
- Remove if one is seen.
- Try 2 rescue breaths.
- Repeat until EMS responders arrive or the obstruction is removed and the patient begins to breathe on his or her own.

The American Red Cross guidelines for treating choking in infants or babies one year or younger are similar to the guidelines mentioned above for the American Heart Association.

Medical Treatment

Treatment begins when local emergency medical services (EMS) arrive. They have several ways to treat a choking person. In addition to being skilled in the choking treatment and CPR, they also may have several tools to assist them in clearing the airway.

Intubation: a breathing tube is passed into a person's windpipe (trachea). This may push the object that is obstructing the airway out of the way enough to provide air to the lungs.

To perform intubation, a metal scope is inserted into the back of the throat to aid in seeing the vocal cords, which mark the opening of the trachea.

If, while using this scope, the object causing the obstruction can be seen, it may then be removed with a long instrument called a Magill forceps.

If attempts to intubate a person with a complete airway obstruction are unsuccessful, EMS personnel may have to perform a surgical procedure called a cricothyrotomy. This involves cutting the neck and making a hole in the trachea just below the Adam's apple, through which a breathing tube is inserted. This tube should enter the trachea below the spot that is blocked by the foreign body.

Once at the hospital, a doctor may use a bronchoscope to remove the object. Bronchoscopy involves inserting a flexible fiberoptic scope into the airway (trachea). If something is found, this scope also has attachments that the doctor can use to remove the object.

To perform this procedure, the person is heavily sedated and the nose numbed with a topical gel. The flexible scope is placed through the nose into the back of the throat and then guided into the trachea.

Most people do not remember this procedure being done. It can be performed quickly if a person is in distress, and sedation is always used.

If all of these maneuvers fail, the choking person will be taken to the operating room to have the foreign body removed and a clear airway established surgically.

Prevention

Be prepared to help: If you are ever in this situation as an observer you will want to be trained in the simple, yet life-saving choking treatment methods and CPR.

Attend a training class: Many are available through the American Heart Association, the American Red Cross, hospitals, worksites, and other local organizations.

Asthma

Asthma is a disease that affects the breathing passages of the lungs (bronchioles). Asthma is caused by chronic (ongoing, long-term) inflammation of these passages. This makes the breathing passages, or airways, of the person with asthma highly sensitive to various "triggers."

When the inflammation is "triggered" by any number of external and internal factors, the passages swell and fill with mucus.

Muscles within the breathing passages contract (bronchospasm), causing even further narrowing of the airways.

This narrowing makes it difficult for air to be breathed out (exhaled) from the lungs.

This resistance to exhaling leads to the typical symptoms of an asthma attack.

Because asthma causes resistance, or obstruction, to exhaled air, it is called an obstructive lung disease. The medical term for such lung conditions is chronic obstructive pulmonary disease or COPD. COPD is actually a group of diseases that includes not only asthma but also chronic bronchitis and emphysema.

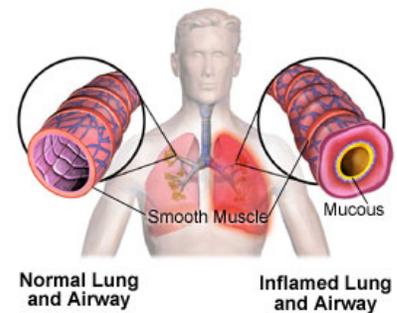
Like any other chronic disease, asthma is a condition you live with every day of your life. You can have an attack any time you are exposed to one of your triggers. Unlike other chronic obstructive lung diseases, asthma is reversible.

Asthma cannot be cured, but it can be controlled.

You have a better chance of controlling your asthma if it is diagnosed early and treatment is begun right away.

With proper treatment, people with asthma can have fewer and less severe attacks.

Without treatment, they will have more frequent and more severe asthma attacks and can even die.



Asthma is on the rise in the United States and other developed countries. We are not sure exactly why this is, but these factors may contribute.

We grow up as children with less exposure to infection than did our ancestors, which has made our immune systems more sensitive.

We spend more and more time indoors, where we are exposed to indoor allergens such as dust and mold.

The air we breathe is more polluted than the air most of our ancestors breathed.

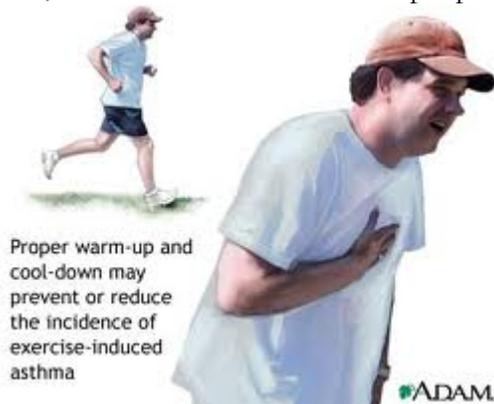
Our lifestyle has led to our getting less exercise and an epidemic of obesity. There is some evidence to suggest an association between obesity and asthma.

Asthma is a very common disease in the United States, where more than 17 million people are affected. A third of these are children.

Asthma affects all races and is slightly more common in African Americans than in other races.

Asthma affects all ages, although it is more common in younger people. The frequency and severity of asthma attacks tend to decrease as a person ages.

Asthma is the most common chronic disease of children.



Asthma has many costs to society as well as to the individual affected.

Many people are forced to make compromises in their lifestyle to accommodate their disease.

Asthma is a major cause of work and school absence and lost productivity.

Asthma is one of the most common reasons for emergency department visits and hospitalization.

Asthma Causes

The exact cause of asthma is not known.

Each person with asthma has his or her own unique set of triggers. Most triggers cause attacks in some people with asthma and not in others. Common triggers of asthma attacks are the following: exposure to tobacco or wood smoke, breathing polluted air, inhaling other respiratory irritants such as perfumes or cleaning products, exposure to airway irritants at the workplace, breathing in allergy-causing substances (allergens) such as molds, dust, or animal dander, an upper respiratory infection, such as a cold, flu, sinusitis, or bronchitis, exposure to cold, dry weather, emotional excitement or stress, physical exertion or exercise, reflux of stomach acid known as gastroesophageal reflux disease, or GERD, sulfites, an additive to some foods and wine, and menstruation: In some, not all, women, asthma symptoms are closely tied to the menstrual cycle.

Risk factors for developing asthma: hay fever (allergic rhinitis) and other allergies -- this is the single biggest risk factor; eczema: another type of allergy affecting the skin; and genetic predisposition: a parent, brother, or sister also has asthma.

Asthma Symptoms

When the breathing passages become irritated or infected, an attack is triggered. The attack may come on suddenly or develop slowly over several days or hours. The main symptoms that signal an attack are as follows: wheezing, breathlessness, chest tightness, coughing, and difficulty speaking.

Symptoms may occur during the day or at night. If they happen at night, they may disturb your sleep.

Wheezing is the most common symptom of an asthma attack.

Wheezing is a musical, whistling, or hissing sound with breathing.

Wheezes are most often heard during exhalation, but they can occur during breathing in (inhaling).

Not all asthmatics wheeze, and not all people who wheeze are asthmatics.

Current guidelines for the care of people with asthma include classifying the severity of asthma symptoms, as follows:

Mild intermittent: Includes attacks no more than twice a week and nighttime attacks no more than twice a month. Attacks last no more than a few hours to days. Severity of attacks varies, but there are no symptoms between attacks.

Mild persistent: Includes attacks more than twice a week, but not every day, and nighttime symptoms more than twice a month. Attacks are sometimes severe enough to interrupt regular activities.

Moderate persistent: Includes daily attacks and nighttime symptoms more than once a week. More severe attacks occur at least twice a week and may last for days. Attacks require daily use of quick-relief (rescue) medication and changes in daily activities.

Severe persistent: Includes frequent severe attacks, continual daytime symptoms, and frequent nighttime symptoms. Symptoms require limits on activities.



Just because a person has mild or moderate asthma does not mean that he or she cannot have a severe attack. The severity of asthma can change over time, either for better or for worse.

When to Seek Medical Care

If you think you or your child may have asthma, make an appointment with your health-care provider. Some clues pointing to asthma include the following: wheezing, difficulty breathing, pain or tightness in your chest, and recurrent, spasmodic cough that is worse at night.

If you or your child has asthma, you should have an action plan worked out in advance with your health-care provider. This plan should include instructions on what to do when an asthma attack occurs, when to call the health-care provider, and when to go to a hospital emergency department. The following are general guidelines only. If your provider recommends another plan for you, follow that plan.

If you are having an asthma attack and have severe shortness of breath or are unable to reach your health-care provider in a short period of time, you must go to the nearest hospital emergency department.

Do not drive yourself to the hospital. Have a friend or family member drive. If you are alone, call 911 immediately for emergency medical transport.

Lightning Strike

Lightning strikes are weather-related medical emergencies. Lightning is consistently among the top 4 weather-related killers. In typical years, lightning kills more people in the United States than any other natural disaster (with the exception of flash floods), including tornadoes.

The National Weather Service reports more than 3,000 deaths a year from cardiac arrest related to lightning strikes. There are 4-5 times as many people injured.

Most people killed or injured by lightning are outside doing recreational activities such as fishing, boating, swimming, or playing sports. Others are working outdoors at construction jobs. Farmers are often struck, too.

Lightning Strike Causes

Injury from a lightning strike may occur in any of these ways: Directly strikes a person.

Contact strike: A person is touching an object (such as a tree or pole) that has been struck.

Side splash: Lightning jumps from the primary strike object traveling to ground.

Ground strike: Lightning strikes the ground and the spreads out in a circle.

Blunt injury: A person is thrown violently from the lightning strike or from the explosive force that occurs as surrounding air is superheated and rapidly cooled.

Upward streamer: When a low-energy electrical charge streams upward to meet a downward leader, it may carry enough current to cause electrical injury even if it does not connect with the downward current to complete the lightning strike.

Lightning Strike Symptoms

A person struck by lightning may have immediate cardiac arrest. In others, you may see no outward signs of injury. Some people may lose consciousness for varying periods. They may seem confused and not remember what happened. Lightning may even flash over the outside of a person, blow off their clothes, and leave few obvious signs of injury.

Lightning may cause numerous other injuries:

Heart damage or cardiac arrest may occur.

Up to two-thirds of the seriously injured people struck by lightning have keraunoparalysis—a temporary paralysis unique to lightning strike.

Victims may experience superficial burns. Contrary to common belief, deep burns are rare. They occur in fewer than 5% of lightning injuries.

Various types of broken bones and dislocations may be caused by lightning.

Skull fractures and cervical spine (neck) injuries may result from associated blunt trauma.

Lungs may be damaged, causing shortness of breath.

Eye injury may cause immediate visual problems or delayed cataract formation.

The eardrum is commonly ruptured. This causes pain, hearing loss, and dizziness.

When to Seek Medical Care

Call 911 emergency services to transport a person for any of these reasons:

- Any period of unconsciousness
- Paralysis
- Chest pain
- Shortness of breath
- Back or neck pain
- Obvious deformity of an extremity indicating a possible broken bone
- Any noticeable burns

Lightning Strike Treatment

Start CPR immediately on any person who is not breathing and does not have a pulse. Call 911 for emergency medical services. Instructions for doing CPR can be given over the phone by the 911 dispatch center.

Any person suspected of being injured by lightning should be evaluated in a hospital's emergency department, even if injuries are not obvious.

Medical Treatment

In general, if you have no symptoms and a normal ECG, you may be sent home with a referral to any specialists if needed.

The doctor will treat those injuries that are discovered on the physical examination.

Head injury indicated by a loss of consciousness and or confusion is frequently treated by observation in the hospital.

Possible injury to the heart that shows up on an abnormal ECG or in blood enzyme levels is usually managed in the hospital by observation and medicine if needed.

Ear and eye injuries are treated as needed with referral to an appropriate specialist.

Keraunoparalysis is usually temporary but may require observation in the hospital.

Spine injuries usually require hospitalization for observation or surgical stabilization.

Broken bones may be treated with splinting or may require surgery.

Symptoms of nerve injury (numbness, tingling) can generally be monitored by a neurologist.



Prevention

The following tips may help you avoid being struck by lightning. Lightning may occur well in front of or behind a thunderstorm.

Avoid being outside in open spaces during thunderstorms. If you hear thunder, you are in range for a lightning strike. You need to seek shelter immediately if you are outside.

Lightning can travel 10-12 miles ahead of a storm and seem to come out of a clear blue sky.

Take cover from storms, avoiding the highest elevation areas and tall objects.

Do not carry or hold tall metal objects during thunderstorms. Drop any golf clubs, fishing poles, or baseball bats. Remove metal objects such as a baseball helmet.

If lightning has struck the immediate area, remember that lightning can strike the same place twice.

If you cannot find shelter, crouch down in a catcher's stance. Put your hands on your knees or place them over your ears to protect against hearing damage from thunder. If other people are with you, stay 15 feet apart.

A fully enclosed metal vehicle such as a car or school bus can be a good shelter. Close all windows and do not touch anything metal connected to the vehicle. A golf cart is not a suitable shelter. Heavy equipment operators may stay inside the machine's closed canopy, but do not step out to seek shelter.

Even if you are inside a building, close all windows and stay away from them. Do not use the land-line telephone or electrical appliances including computers. Lightning may strike outside lines and travel inside.

Little League requires persons to wait at least 30 minutes after the last observed lightning strike or thunder before you venture outside your sheltered area.

The simple safety slogan of the National Lightning Safety Institute is this: If you can see it (lightning), flee it (take shelter). If you can hear it (thunder), clear it (stop your activities).



Concussions

A concussion is a type of traumatic brain injury. Concussions are caused by a bump or blow to the head. Even a 'ding', or 'getting your bell rung', or what seems to be a mild bump or blow to the head can be serious. One cannot see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child tells you about any symptoms of a concussion, or if you notice the symptoms yourself, seek medical attention right away.

Signs of a Concussion

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs and symptoms of a concussion:

- Appears Dazed or Stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily, balance problems, or dizziness
- Answers questions slowly
- Loses Consciousness (even briefly)
- Shows mood, behavior, or personality changes

If you think your Child has a Concussion

1. Seek medical attention right away by a Medical Professional. They will be able to decide how serious the concussion is and when it is safe for your child to return to regular activities, including sports.
2. Keep your child out of play. Concussions take time to heal. Don't let your child return to play the day of the injury and until a health care professional says it's OK. Children who return to play too soon - - while the brain is still healing - - risk a greater chance of having a repeat concussion. Repeat or later concussions can be very serious.
3. Tell your child's coach about any previous concussion. Coaches should know if your child had a previous concussion.

WSLL SAFETY DISCLAIMER NOTICE

Using Information Found in this Document

Information provided in this document is intended to educate the reader about certain medical conditions and certain possible treatments. It is not a substitute for examination, diagnosis, and medical care provided by a licensed and qualified health professional. If you believe you, your child, or someone you know, suffer from the conditions described herein, please see your health care provider. Do not attempt to treat yourself, your child, or anyone else without proper medical supervision.

WSLL LEAGUE DIRECTORS INFORMATION

Majors: League Directors for Majors is posted on the West Springfield Little League Web Page under the “Board of Directors” information link. The page contains all contact information for the current League Directors.

AAA: League Directors for AAA is posted on the West Springfield Little League Web Page under the “Board of Directors” information link. The page contains all contact information for the current League Directors.

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A: League Directors for A is posted on the West Springfield Little League Web Page under the “Board of Directors” information link. The page contains all contact information for the current League Directors.

T-Ball: League Directors for T-Ball is posted on the West Springfield Little League Web Page under the “Board of Directors” information link. The page contains all contact information for the current League Directors.

5-T: League Directors for 5-T is posted on the West Springfield Little League Web Page under the “Board of Directors” information link. The page contains all contact information for the current League Directors.

ON FIELD EMERGENCIES - CALL 911

SAFETY OFFICER - Ken Nehilla, phone: 703-455-3389, email: kneh617036@aol.com;

FIELDS AND FACILITY MANAGERS

BYRON CHIEF: Dave Pollack, phone: 703-569-1899, email: dave.pollack@gmail.com

BURKE CHIEF: Steve Puryear, phone: 703-254-4258, email: stevenpuryear@gmail.com

LEAGUE UMPIRES

Majors CHIEF: Al Beyer, Majors support, email: waltsoup@yahoo.com

Minors CHIEF: Ralph Yates, Minors support, email: ralphola@gmail.com

LEADERSHIP ROLES

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EXECUTIVE VP	Mike Williams	703-339-3770
PLAYER AGENT	Todd Harding	703-543-8696
SAFETY OFFICER	Ken Nehilla	703-455-3389
SECRETARY	Heather Crocetto	703-451-1336
VP BASEBALL OPS	John Mielcarek	703-203-7934
TREASURER	Shawn James	703-485-9324
VP PLAYER SUPPORT	Scott Mills	703-644-2882