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INTRODUCTION
Lee University
Athletic Training Education Program

INTRODUCTION

Athletic training is recognized by the American Medical Association as an allied health care field. A Certified Athletic Trainer (ATC) is an educated and skilled professional that meets the entry-level educational competencies, clinical proficiencies, and clinically integrated proficiencies established by the National Athletic Trainers’ Association Education Council (NATAEC) and successfully complete the Board of Certification (BOC) examination.

An athletic trainer is knowledgeable and skilled in the following areas:

1. Evidence-based practice
2. Prevention and health promotion
3. Clinical examination and diagnosis
4. Acute care of injuries and illnesses
5. Therapeutic interventions
6. Psychosocial strategies and referral
7. Healthcare administration
8. Professional development and responsibility

To be eligible to become an ATC, one must complete an athletic training education program (ATEP) and graduate from an accredited college or university in the United States. Completing the ATEP ensures that a student will have addressed all educational competencies and clinical proficiencies established by the NATAEC, will possess the entry level knowledge and skills of a certified athletic trainer, and will be eligible to take the BOC examination.

Certified athletic trainers practice in a variety of settings and roles. The traditional setting, where many athletic trainers are employed, is the athletic training room within an interscholastic or intercollegiate athletic program. Other sites include professional sports, hospitals, fitness and wellness centers in an industrial setting, physical therapy facilities, sports medicine clinics, and others.

The Athletic Training Room provides a unique learning environment for athletic training students: They can apply knowledge, acquire new skills, and practice these skills under the
guidance of a certified athletic trainer. Under the supervision of certified athletic trainers, students of athletic training have the opportunity to gain “hands on” experience through the care of athletes and the physically active. The athletic training room will provide a means to integrate academic knowledge with clinical practice.

Weekly meetings, daily proficiency practice and evaluation, and continual written and verbal feedback provide a way to facilitate the integration of academic knowledge and clinical skills. While student feedback is important for student growth, the student’s ability to communicate (written and verbally) will develop through peer teaching and clinical documentation (see Appendix A for medical terms and abbreviations). This competency-based program has been developed to guide students through their education experience, enhance the learning environment, provide faculty and staff athletic trainers with an assessment tool, and optimize the quality of care provided to the physically active population.
MISSION STATEMENTS

The NATA

The mission of the National Athletic Trainers' Association is to enhance the quality of health care provided by certified athletic trainers and to advance the athletic training profession.


Lee University

Lee University is a Christian institution which offers liberal arts and professional education on both the baccalaureate and graduate levels through residential and distance programs. It seeks to provide education that integrates biblical truth as revealed in the Holy Scriptures with truth discovered through the study of arts and sciences and in the practice of various professions. A personal commitment to Jesus Christ as Savior is the controlling perspective from which the educational enterprise is carried out. The foundational purpose of all educational programs is to develop within the students’ knowledge, appreciation, understanding, ability and skills which will prepare them for responsible Christian living in a complex world.

Athletic Training Education Program

The Lee University Athletic Training Education Program serves as integral part of the Department of Health, Exercise Science, and Secondary Education (HESSE) under the direction of the College of Education (See Appendix D, Academic Administrative Structure/Personnel Directory). The function of the program shall be to enhance health care for the habitually active community of the university. The program will service the college community by endeavoring to help its members attain higher levels of performance through proper health care and appropriate injury/illness preventive measures.

The program’s educational philosophy encompasses current research and formal instruction in prevention, recognition, evaluation, and rehabilitation of conditions and injuries sustained by the physically active in various settings. An ATEP student will have the opportunity to develop applied technical and clinical skills incorporating analytical problem-solving abilities to assist with the daily operation of traditional and non-traditional athletic training settings.
It is an aim of the program to establish and maintain a corps of athletic training students that shall be trained in the educational competencies and clinical proficiencies required for an entry-level athletic trainer. The **vision** of our professional baccalaureate Athletic Training Program is to develop the students’ knowledge, appreciation, understanding, and clinical reasoning which will prepare them for responsible Christian living in a complex world as a health care provider. The program **mission** is to teach students’ three core values, which include; (1) knowledge and skill competency, (2) critical and integrative thinking and (3) personal, professional, and ethical behaviors of a practitioner.

**Critical & Integrative Thinking**
**Knowledge & Skill Competency**
**Personal, Professional & Ethical Practitioner**

**Foundational knowledge and competent clinical skills that prepare allied health care workers to function in a complex world.**

**Critical appraisal of evidence based practice that will impact the quality of patient care through connecting integrative thoughts.**

**Individual skills and attitudes of a life-long learner which represent professional responsibility to society and self in regard to both legal and ethical issues.**
Foundational Behaviors of Professional Practice

These basic behaviors permeate every aspect of professional practice and should be incorporated into instruction in every part of the educational program. The behaviors in this section comprise the application of the common values of the athletic training profession as stated in the Athletic Training Educational Competencies (5th ed.).

Primacy of the Patient

- Recognize sources of conflict of interest that can impact the client’s/patient’s health.
- Know and apply the commonly accepted standards for patient confidentiality.
- Provide the best health care available for the client/patient.
- Advocate for the needs of the client/patient

Team Approach to Practice

- Recognize the unique skills and abilities of other healthcare professionals.
- Understand the scope of practice of other healthcare professionals.
- Execute duties within the identified scope of practice for athletic trainers.
- Include the patient (and family, where appropriate) in the decision-making process.
- Work with others in effecting positive patient outcomes.

Legal Practice

- Practice athletic training in a legally competent manner.
- Identify and conform to the laws that govern athletic training.
- Understand the consequences of violating the laws that govern athletic training.

Ethical Practice

- Comply with the NATA’s Code of Ethics (See Appendix C) and the BOC’s Standards of Professional Practice.
- Understand the consequences of violating the NATA’s Code of Ethics and the BOC’s Standards of Professional Practice.
- Comply with other codes of ethics, as applicable.
Advancing Knowledge

- Critically examine the body of knowledge in athletic training and related fields.
- Use evidence-based practice as a foundation for the delivery of care.
- Appreciate the connection between continuing education and the improvement of athletic training practice.
- Promote the value of research and scholarship in athletic training.
- Disseminate new knowledge in athletic training to fellow athletic trainers, clients/patients, other healthcare professionals, and others as necessary.

Cultural Competence

- Demonstrate awareness of the impact that clients’/patients’ cultural differences have on their attitudes and behaviors toward healthcare.
- Demonstrate knowledge, attitudes, behaviors, and skills necessary to achieve optimal health outcomes for diverse patient populations.
- Work respectfully and effectively with diverse populations and in a diverse work environment.

Professionalism

- Advocate for the profession.
- Demonstrate honesty and integrity.
- Exhibit compassion and empathy.
- Demonstrate effective interpersonal communication skills.

Summary

The ATEP is progressive and sequential and is designed around the cohort model. Course sequence is developed to fit with Lee University and HESSE departmental requirements to provide a soundly structured educational experience (See Appendix F). The program strives to incorporate the competencies and proficiencies in both the didactic and clinical experiences of the student. Special emphasis is given to senior students as they complete numerous clinically integrated proficiencies. The faculty and clinical staff of the program make every effort to meet the following goals, outcomes, and student learning objectives:
Program Goal - **Knowledge Competency:** Foundational knowledge and competent clinical skills that prepare allied health care workers to function in a complex world.

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<thead>
<tr>
<th>Program Learning Outcomes:</th>
<th>Student Learning Objectives:</th>
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<td>1. The curriculum will produce students with exceptional oral and written communication skills.</td>
<td>1.1 Students will acquire written and verbal communication through peer teaching, clinical documentation, and professional interactions.</td>
</tr>
<tr>
<td>2. The curriculum will provide educational training in risk management, health promotions, and injury prevention technique. (CAATE: PHP).</td>
<td>2.1 Students will demonstrate appropriate documentation, and skills through live and mock situations that prevents risk and injury in an active population. 2.2 Students will design an exercise and nutritional plan for other students needing guidance in healthy living.</td>
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<tr>
<td>3. The curriculum will provide knowledge of clinical examination and diagnosis with an emphasis in pathophysiology of injuries and illness. (CAATE: CE).</td>
<td>3.1 Students will demonstrate accurate and efficient diagnostic abilities and understanding of pathophysiology through clinical and scenario based situations of disabilities and general medical conditions. 3.2 Students will demonstrate inter-professional collaboration during clinical evaluations which enhances overall health of the population.</td>
</tr>
<tr>
<td>4. The curriculum will provide knowledge of acute care of injuries and illness of the habitually active throughout different ages (CAATE: AC).</td>
<td>4.1 Students will demonstrate clinical effectiveness in responding to emergency situations through the treatment of acute illnesses and injuries.</td>
</tr>
<tr>
<td>5. The curriculum provides excellent community-centered service and instruction in the knowledge of health care administration (CAATE: HA).</td>
<td>5.1 Students will develop policy and examples that effectively demonstrates an understanding of the different facets of healthcare administration (e.g insurance, policies, EAP's, budget, etc.)</td>
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**Program Goal - Critical and Integrative Thinking:** Critical appraisal of evidence based practice that will impact the quality of patient care through analysis and synthesis of content and clinical experience

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<tr>
<th>Program Learning Outcome</th>
<th>Student Learning Objective</th>
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<td>6. The program provides multiple clinically integrated proficiency scenarios and projects that demonstrate critical and integrated thinking.</td>
<td>6.1 Students will develop care plans relative to patients’ physical, mental, and emotional needs.</td>
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<tr>
<td>7. The program establishes that each student will make various recommendations on patient care (or mock patient care) which reflects students’ level of expertise in selecting appropriate treatment and referral post injury (e.g. pharmacological, nutritional, exercise, modalities, manual therapy, and non-traditional options) (CAATE: TI).</td>
<td>7.1 Students will utilize evidence based research to produce case studies and rehabilitation plans for injured patients. 7.2 Students will select most appropriate tool to provide patient care which is at their disposal based on equipment availability. 7.3 Students will develop a medication dispensing station based on pharmacological laws of distribution and packaging. 7.4 Students will demonstrate specialized skill sets while encountering inter-professional collaboration during treatment decisions which enhances overall health of the population.</td>
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<tr>
<td>8. The curriculum affords multiple student learning encounters or mock scenarios which adequately prepare students to handle psychosocial interventions (CAATE: PS).</td>
<td>8.1 Students will make recommendations on patient care (or mock patient care) which reflects students’ level of expertise in selecting appropriate treatment and referral for psychosocial issues.</td>
</tr>
<tr>
<td>Program Goal - Personal, Professional &amp; Ethical Practitioner: Individual skills and attitudes of a life-long learner which represent professional responsibility to society and self in regard to both legal and ethical issues.</td>
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<tr>
<td><strong>Program Learning Objective</strong></td>
<td><strong>Student Learning Objectives:</strong></td>
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<td>9. The program provides an opportunity for students to produce collaborative research with faculty and preceptors; and/or design an individual research proposal which will enhance their success in graduate school (CAATE: EBP).</td>
<td>9.1 Students will incorporate patient-centered outcome measures to evaluate the quality of care provided. 9.2 Students will produce collaborative research with faculty and/or design an individual research proposal which will enhance their ability to critically think. 9.3 Students will produce quality patient care based on researching best evidence available at any particular time.</td>
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<td>10. The program advances the profession of athletic training by training students to utilize EBP research to disseminate information through workshops, websites, clubs, lecture(s), brochure(s), and/or symposium(s)(CAATE: PD).</td>
<td>10.1 Students will attend educational symposiums to enhance professional growth and promote BOC success. 10.2 Students will demonstrate professional and competent lectures frequently across campus and in the community. 10.3 Students’ professionalism will develop as they meet program benchmarks each year.</td>
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<td>11. The curriculum is designed to produce students with an exceptional awareness of cultural diversity and a cross cultural experience that deepens the students’ philosophical appreciation of caring for others across the world.</td>
<td>11.1 Students will exhibit cultural awareness behaviors and work respectively with diverse populations. 11.2 Students will encounter volunteerism and cross cultural experiences that will enhance their professional and personal growth. 11.3 Students will develop a sense of servant leadership through the integration of faith and practice.</td>
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<td>12. The program provides training and application of the NATA foundational behaviors and skills of being an ethical and legal practitioner of athletic training (CAATE: PD).</td>
<td>12.1 Students will exhibit behaviors and encounter faculty that are ethical, legal and competent. 12.2 Students will develop mentorship with faculty, preceptors, and peers in order to foster a professional code of conduct that reflects Christian commitment. 12.3 Upon graduation, the students will pursue employment and/or further education in a desired allied healthcare setting.</td>
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PROGRAM OVERVIEW

The ATEP at Lee University is committed to providing a quality education with clinical and professional experiences for students interested in pursuing employment in athletic training and to providing the best possible medical care to student-athletes, visiting athletic teams, and the Lee campus community. This manual will provide athletic training students with information vital to a timely completion of the educational program.

In accordance with the guidelines set forth by the CAATE standards (Commission on Accreditation for Athletic Training Education) for the establishment of clinical components of curriculum programs in athletic training, this athletic training education program has been developed to provide a standard of clinical education for students interested in the athletic training profession and who have been admitted to the Lee University Athletic Training Education Program.

The competencies, clinical proficiencies, and clinically integrated proficiencies (CIP) have been identified as necessary for effective functioning as an entry-level certified athletic trainer. A role delineation study completed by the BOC identified job responsibilities and tasks performed by certified athletic trainers in high schools, colleges/universities, and amateur and professional athletic organizations throughout the United States.

These competencies, clinical proficiencies and CIPs serve as a guide for the development of educational programs leading to certification as an athletic trainer and are intended to assist athletic training faculty, staff, and students in identifying knowledge and skills to be mastered.

**Professionalism**

Students in the Athletic Training Education Program at Lee University are expected to conduct themselves in a manner reflecting pride in the profession and in themselves. Athletic training students have the unique opportunity to be part of the health care team at the Lee University and its affiliated and allied sites. While much is expected and demanded of each athletic training student, it is critical for the student to be aware that the ultimate decisions relating to the care of athletes, the work schedules of athletic training students, and all other
aspects of athletic training remain with the supervising certified athletic trainer. Any concerns should be discussed with the supervising athletic trainer.

The student’s first commitment is to academic preparation. If athletic training responsibilities conflict with academic policies established by a professor, it is your responsibility to bring this matter to the attention of the clinical instructor and make suitable alternate arrangements. The clinical setting of the athletic training education program is designed to be the application of academic preparation.

**Learning Experiences**

Experience is the greatest teacher. Students should strive for a happy medium between making decisions where he/she feels capable or asking for help when necessary. If students have questions, chances are their peers will have questions also, therefore, do not hesitate to ask. Students should use every opportunity to watch orthopedic evaluations and be sure they understand the reasoning and thoughts concerning examinations, treatments, and rehabilitation decisions. Students should examine and evaluate injuries whenever possible.

**Professional Relationships**

The relationships that will be developed with team members will last a long time. If students coddle the athletes under their care, they will take advantage of the student. If students are too demanding with the athletes, the student will lose the athletes’ respect. Be firm with expectations for each athlete and treat all athletes the same. Do not allow any team members or coaching staff access to the medical kit without prior permission. When assigned to a team, the student, under the supervision and advice of the clinical instructor, is responsible for the day-to-day health care of that team. Under the council of his/her clinical instructor, the student should make informed medical decisions objectively and stick to his/her decisions. By using sound judgment, the student will gain the respect he/she deserves.

The athletic training staff and students must maintain a good working relationship with the coach and staff by informing the coach daily of the status of injured athletes and, when appropriate, by recommending alternate forms of workouts (aquatic workouts for example).
This reinforces the team concept that the coaching and athletic training staff members are working toward the same goal: peak performance of each athlete and the team as a whole.

A student should communicate clearly, in lay terms, when taking the opportunity to educate a coaching staff member regarding injury prevention and care when necessary. Using a lot of medical terms may sound impressive, but the coach may not understand what the student is trying to communicate. When disagreeing with the coach, the student should step back and try to see both points of view. The student must remember that he/she is an advocate for the athlete’s health and optimum return to full participation.

While confidences given the athletic training student by athletic team members must not be betrayed, certain factors that involve the team’s status and effectiveness may have to be carefully considered. These confidences may be discussed with the supervising athletic training staff, leading to a decision as to whether or not the coaching staff shall be informed of the issue. Remain positive about the program and all involved.

**Social Media Policy**

A student should not use social media as a communication tool during clinical experiences. Keeping a professional relationship can get difficult when athletes are peers, therefore eliminating dating and social networking during clinical rotations with athletes in respective clinical rotations will be necessary. All off-campus patient contact will maintain a zero tolerance for social media. Due to some patients being minors as well as other patients being considerably older than the traditional college-age student.
The Athletic Training Education Program
@ Lee University

Policy and Procedures

Taping Practice Today
COMPETITIVE ADMISSIONS POLICY

The curriculum phase is highly competitive. Entry into the program of the athletic training curriculum is NOT guaranteed upon completion of the pre-professional phase. The determining factors include: the success of the pre-professional experience, meeting all academic prerequisites, and how many students are currently enrolled in the program. The number of students admitted into the program varies from year to year.

Selection is centered on academic achievement and athletic training experiences. Academic achievement involves successful completion of CHEM 101 (Introduction to general, organic, and biochemistry), HSCI 292 or 293 (Human Anatomy and Physiology I and II), ATEP 199 (Introduction to Athletic Training), ATEP 200 (Care and Prevention of Athletic Injuries), and ATEP 353, 353L (First Aid/CPR For Professional Rescuer), and maintaining an over-all grade point average (GPA) of 2.75 on a 4-point scale.

Any student who will have completed all prerequisites by the end of December of the sophomore year is eligible to apply for admission. Applications are available from the Director of the Athletic Training Education Program, on the Lee University ATEP website, and in the student handbook (See Appendix H). On-campus applicants must submit all application material online to subscribed software (evalue.net). If the student needs electronic support, the HESSE secretary Diana Hendershott will assist students. Information should be submitted by December 1 each year. If a transfer student would like to apply, they are welcome to send materials to:

Lee University,
C/O Diana Hendershott
P.O. Box 3450
Cleveland, TN, 37320.

The following requirements are needed in order to apply to the curriculum phase of the athletic training education program.

- Must have achieved a minimum cumulative GPA of 2.75 for ALL course work attempted.
• Must have achieved a minimum of 85% on the entrance exam.

• Must complete background check and waiver (Appendices I & J). The financial expense for the background check is the student’s responsibility and will be between 50 and 75 dollars.

• Must be an Athletic Training major.

• Must have completed a basic college-level biology or human anatomy course (ex. BIOL 109, HSCI 292, or HSCI 293) with a grade of “C-” or higher.

• Must have completed a college-level First Aid/CPR course (ex. ATEP 353 – Safety, First Aid, and CPR for the Professional Rescuer) with a grade of “B-” or higher. The student must have and maintain a current Professional Rescuer card (by American Red Cross, American Heart Association, National Safety Council or equivalent).

• Must have completed a basic college-level athletic training course (ex. ATEP 200 – Care and Prevention of Athletic Injuries) with a grade of “B-” or higher.

• Must sign the confidentiality form (Appendix K), technical standard form (Appendix L), and policy and procedure agreement form (Appendix M).

Athletic training experiences are the second category of prerequisites. The requirements include:

• Obtaining a recommendation from a BOC Certified Athletic Trainer that knows the student and his/her interest and commitment to athletic training (See Appendix N).

• Completing all clinical proficiencies outlined for ATEP 200 and ATEP 353.

In addition to the two categories of prerequisites, professional goals and work experience related to any of the allied health fields (e.g. rescue squad, physical therapy aide, etc.) are taken into consideration when weighing athletic training experiences. Students should provide proof of these experiences and a letter describing their desire to be accepted into our athletic training education program (essay should be approximately 250 words). Students will be notified, in writing, of the outcome of their application. If the application is accepted, the student will begin the curriculum phase. If, however, the application is rejected, the student will have the opportunity to re-apply the following year. Admission decisions may be appealed to the Program Director within two weeks after official notification.

Students wishing to apply for admission to the Athletic Training Education Program must submit application materials by the end of the fall. Students, including transfer students, may
apply for admission during any academic year but must realize that they will devote a minimum of five academic semesters, excluding summer terms, to the program of study.

Regardless of a student’s academic standing, applications must be completed and submitted on-line or given to the HESSE secretary Diana Hendershott by the end of the fall semester proceeding the academic year for which the student wishes to be admitted into the program. Applications received after December cannot be guaranteed consideration for the ensuing academic year. Optimum consideration will be given to students who:

- Have an overall GPA of 2.75 at the time the application is submitted;
- Successfully completed ATEP 200 with a final grade not lower than a B-;
- Have secured recommendations from two individuals (e.g., employers, instructors, and certified athletic trainers) who know the student and his/her work ethics (at least one recommendation must be made by an ATC). Recommendation forms can be downloaded off the ATEP website.

**FEES FOR PROGRAM**

Each student will incur background check fees to apply to the program. These fees are estimated at 50 to 75 dollars. Additionally, students who elect to take the hepatitis A immunization on campus could incur a fee of 65 dollars. Once accepted into the program students will have the expense of some clothing in order to meet the professional dress code. This fee varies considerably but for some the cost is between 100 to 200 dollars. The program currently uses Evalue as its electronic administrative system. This program will cost each student a 75 dollars fee per semester beginning their sophomore year. This fee is attached to the practicum lab classes (ATEP 201, 300, 301, 400, 401) and ATEP 200. Students will begin off-campus travel the beginning of their junior year in which they will need to provide their own transportation; including the gasoline expenses. Currently our sites are less than 50 miles away. The final fee is related to keeping the CPR and first aid certification current, once they are accepted into the program. The initial certification
expense is covered by tuition dollars when the student enrolls in first aid and CPR for the professional rescuer as a class credit ATEP 353 and ATEP 353L. However, after initial certification expires the student is then responsible to keep the first aid, and CPR with AED and Oxygen training current. This fee can cost between 35 to 75 dollars dependent on which organization & instructor the student elects to use for the re-credentialing.

RETENTION, CONTINUATION, and COMPLETION

In order to remain in the program, students must demonstrate satisfactory progress toward completion of the program. Satisfactory progress includes, but is not limited to, the following:

- Maintaining a minimum overall and semester GPA of 2.75;
- Must have achieved a 85% on the comprehensive benchmark exam;
- No final grade lower than a C- in any course in the Department of Health, Exercise Science, and Secondary Education;
- Satisfactory evaluations with a grade no lower than a C (end of each five week rotation for Juniors and mid- and end of rotation for Seniors) from each clinical instructor;
- No student should deviate from the designed course sequence, if extending your program then practicums must be repeated.
- Provide on-line documentation of current transcript, OSHA certificate, Current CPR for the health care provider, clinical hours, clinical proficiencies, transcripts, and CIP.

Suspension and/or Dismissal from the Program

Unfortunately, student behavior, academic performance, and/or unsatisfactory clinical performance may warrant censure. When implemented, censure could be in the form of reprimand, limits placed on accruing clinical hours, required study hall, or suspension or expulsion from the program. All recommendations for sanctions will be considered by the Athletic Training Committee. The student will not be denied his/her right of due process. Furthermore, suspension could result from the following conditions:
• If the overall GPA falls below a 2.75, the student may be suspended from the program until the minimum GPA requirement has been met;

• If the GPA for ATEP courses fall below a 2.75 or C-, you will be asked to repeat the courses, which may result in delaying graduation;

• If a student scores lower than 85% on the comprehensive benchmark exam, the student may be placed on probation or suspended from the program;

• Violations of departmental or program ethics may result in suspension or dismissal;

• Violating the Confidentiality Agreement may result in dismissal from the program;

• Neglecting administration responsibilities to update on-line documentation for 2 semesters, consecutive or nonconsecutive;

• Neglecting the clinical hour requirements may result in suspension or dismissal.

It is our goal to remediate students whenever possible. If students are placed on probation by the ATEP committee the following plan is implemented:

• 16 clinical hours each week approved by your Preceptor

• 3 hours of supervised tutoring each week (tutoring center will forward ATEP documentation)—Contact Academic Support at 614-8181

• 3 hours of supervised study hall per week verified by the clinical coordinator or other faculty

• 1 meeting per month during the semester to assess current class grades and clinical performance with the Program Director

• Academic Load 12-14 (special consideration will be determined per incident).

Each student will be given a specific remediation plan based on which one of the considerations the student did not fulfill.

**Completion of the Program**

1. Students will have completed the Athletic Training Education Program when they have successfully completed all designated courses, including general education classes and collateral classes, and completed the minimum verified hours of clinical education. Ideally, students should strive for 15 hours of clinical time per week each
semester. A minimum is 12 hours and a maximum is 20 hours per week. In order to be endorsed, students will be required to sign a BOC contract.

The athletic training student will:

a. Provide their Degree Audit to confirm completion or enrolled in all ATP required courses for degree completion, per LU catalog.
b. Have completed 800 clinical hours (minimum requirement)
c. Complete the BOC self-assessment examination (integrated test mode) and provided results to program director, Kelly Lumpkin. The results must be over 70% score within each domain. The results must be completed within the last 60 days. A second attempt is only valid if it has been taken after completing a 30 day study plan. Plans must be written and approved prior to the estimated 30 day plan. These exams are timed and must be completed in the testing center on campus (contact 423-614-8181; a 48 hour notice is necessary to schedule the exam).
d. Complete an in-house Board prep assessment with an 80% score within each domain. The results must be completed within the last 30 days. A second attempt is only valid if it has been taken after completing a 2 week study plan. Study plans must be written and provided at time of endorsement. These exams are timed and must be completed in the testing center on campus (contact 423-614-8181; a 48 hour notice is necessary).
e. Provide the completed ATP exit interview document and attend assigned interview time and date.
f. Provide verbal presentation to peers about study methodology for BOC success.
g. Complete step 1 of BOC registration prior to endorsement (approximately 1 month prior to estimated test date)
h. If the athletic training student is not currently enrolled in the ATP then a formal interview with Program Director either via phone or in-person is necessary.

DISCIPLINARY POLICY

Failure to comply with any of the operational policies and procedures described within the operational policies manual or other unprofessional conduct which would bring dispute or disgrace on the student, the ATEP, the Clinical Site, or the profession, and which would tend to substantially reduce or eliminate the student’s ability to effectively practice that profession
can result in punishment, suspension, or termination of any scholarship funding and/or dismissal from the program. The student will be informed in writing of any disciplinary action and will be given due process. If the offending action is severe enough to warrant suspension or termination, the student will be referred to the Dean of Students at Lee University for appropriate action. All decisions must involve the ATEP Director. In certain circumstances in which the offense warrants immediate action, suspension or termination may ensue without utilizing the first, second, or third offense approach to handling disciplinary actions.

**First Offense**
The student will receive a formal verbal warning during a personal meeting with the ATEP Director. Also, a written document will be placed in the student’s folder describing the offense and the personal meeting outcomes.

**Second Offense**
The student will be placed on probation. The ATEP Director will establish the guidelines of the probation. There will be a formal personal meeting with the appropriate personnel from the ATEP faculty and a written document provided to the student describing the details of the probation period. Also, a written document will be placed in the student’s personal folder.

**Third Offense**
The student may be placed on suspension from accruing clinical hours in the ATEP. The ATEP Director will determine the resulting penalty. There will be a formal personal meeting with the appropriate personnel from the ATEP faculty and a written document provided to the student describing the details of the decision. Also, a written document will be placed in the student’s personal portfolio.

**GRIEVANCE POLICY**
Unfortunately, student behavior, academic performance, and/or unsatisfactory clinical performance may warrant censure. When implemented, censure could be in the form of reprimand, loss of clinical hours accrued during the time frame of the issue under dispute,
suspension or expulsion from the program. Furthermore, suspension could result from the previously mentioned conditions.

If one feels he/she has been treated unfairly or that his/her rights have been disregarded, one may appeal the case to the ATEP administration. A student will not be denied his/her right of due process. The appeals of application process within the ATEP begins with the Program Director before moving to the Department Chair, Dean, and Vice President for Academic Affairs.

**OFF-CAMPUS CLINICAL AND FIELD EXPERIENCES**

Off-campus clinical experiences will be permitted providing the educational experience is not compromised and there is an existing articulation agreement between Lee University and that affiliated site. All off-campus clinical experiences must be approved in writing by the ATEP director prior to beginning the rotation. The supervising ATC at that site must be a preceptor for the Lee University ATEP. It is the student’s responsibility to ascertain that Clinical Education Guidelines (Located in Section 2 of the student manual) are followed throughout all clinical experiences. Failure to adhere to this policy may result in reassignment and forfeiture of accrued hours at that site. Additional clinical and field experiences are available to students who travel with the university’s athletic teams. Field experiences can include watching medical surgeries from varying allied health professionals, or assisting in the medical facilities with nurses, orthopedics, physician assistants or physical therapists which meet the clinical instructor prerequisites as approved by the director of ATEP. Travel to these additional clinical sites is the financial responsibility of the student athletic trainer.

**VERIFICATION OF CLINICAL HOURS**

The BOC no longer require clinical hours as part of the qualifications for taking the certification examination. Although a student does not have to accrue hours for certification as an athletic trainer, certain states may require a specified number of supervised clinical experiences for state licensure. It is the student’s responsibility to maintain current records of clinical hours. A *Verification of Supervision* form (see Appendix O) must be filed for each preceptor during the freshman and some sophomore classes. Once a student enrolls in ATEP
200 the student will begin to document hours through Evalue. A username and password will be given to each student at the beginning of the semester. The student must input hours each week and the preceptor will approve hours on a designated day of the week. If a student waits longer than a week to log his hours (some program exceptions may apply), the preceptor has department permission to not accept those hours as valid and delete them once they notify the student. Each student assumes full responsibility for consequences arising from the loss of or the failure to maintain current records. At the end of the semester the student should run a report in Evalue based on the entire semester of clinical hours and post that report in the section called immunizations and certifications, “1-semester professional hours –on campus (disregard the on-campus title, because all of our preceptors are trained by our clinical coordinator therefore, we consider all hours on-campus, even if they actually occur on an off-campus venue). No unapproved off-campus hours are accepted in our program.

SPORT PARTICIPATION POLICY

Student-athletes who are seeking admission into the ATEP at Lee University must understand that interscholastic athletic participation may interfere with progress through the program. Students who are participating on an athletic team may not accrue clinical hours as an Athletic Training Student with his/her team while in season. Clinical rotations require time commitments on behalf of every student; therefore time management is essential for athletes to be successful in this program. Students should devote their time towards all clinical experiences as agreed between the student and their respective preceptor’s. In special circumstances the student and preceptor may determine a schedule of convenience for both of them.

TRANSFER POLICY

Students who are entering the ATEP will be required to follow the sequence of classes regardless of their academic standing. Transfer students must adhere to the Competitive Admissions Policy established for the ATEP and outlined in the previous section. Typically, the course work for the ATEP, with the exception of ATEP 200 and ATEP 201, will require four semesters to complete, excluding summer sessions. In some instances ATEP 200 and ATEP 353 can transfer but all students must begin with ATEP 201. A student with special
circumstances might be accepted in their junior year but this is rare. Please contact the program director for clarification if you would like special consideration to this policy.

ATHLETIC TRAINING STUDENT CONDUCT

Personal qualities essential for the athletic training professional include loyalty, honesty, maturity, good work ethics, punctuality, dependability, professionalism, and organization. A primary concern is punctuality. While the first year athletic training student may be relatively uninformed about athletic training, he/she must be where assigned and be there on time. Tardiness reflects poorly on the athletic training student and the athletic training program as a whole. Tardiness of the athletic training student may result in late practice or game starts – a major aggravation of coaches – and may cause a lack of confidence in the athletic training staff.

The athletic training student is in a unique position as a member of an athletic team. The athletic training student must try to maintain a close relationship with the athletes and a closer relationship with the coaching staff of which he/she is a part. The athletic training student is not a player, a coach, or a manager.

Loyalty to the University and to the athletic training education program is paramount. The athletic training student, at all times, is a representative of the University and the athletic programs and should behave accordingly. The administrative ladder is directly to the student’s preceptor or faculty member. Students should address all issues to their preceptors or faculty members prior to climbing the administrative ladder. The administrative ladder for clinical issues is preceptor, faculty of practicum class, clinical coordinator, program director, medical director, chair of HESSE, Dean of College of Education, and Vice President of Academic affairs. The administrative ladder for academic issues includes; the faculty, program director, medical director, chair of HESSE, Dean of College of Education, and Vice President of Academic affairs. Due to the nature of our programs close knit educational organization and frequency of high stress levels for students and staff alike, it will best serve the students and the program to try to alleviate any classroom or clinical friction by talking within the department prior to involving outside administrators. Our Medical Director is highly skilled in problem solving; therefore this attribute will be used to strengthen our
program by utilizing this skill more frequently. One area of professionalism is too utilizing the administrative ladder appropriately. This method demonstrates respect for both the administrator’s time, as well as, produces less conflict. If our program is perceived as full of conflict to others who are unaware of the typical trials related to athletic training education then the program is viewed upon by others as unproductive and unsuccessful.

**STANDARD OF DRESS**

Athletic training is a profession recognized by the American Medical Association; hence athletic training students are young professionals. Students should dress and behave like licensed medical professionals in the athletic training room and all other venues, including travel. The standard of dress for all student athletic trainers is business casual. Exceptions would include clinical experiences at an outdoor venue during inclement conditions.

**Goals of dress code:**

1. Present yourself as a medical professional
2. Gain respect by coaches and peers
3. Be able to respond to emergency situations
4. Be able to assist with rehabilitations and demonstrate activities
5. Modesty
   a. Not showing inappropriate skin
   b. Not too tight
   c. Not too loose
6. Model proper dress code to younger students
7. Identify yourself as a student

**Tops:**

1. Tops must be of sufficient length to be tucked in, or in circumstances where a shirt is designed to be un-tucked, a tucked in undershirt must be worn so that the midriff is not exposed.
2. Tops must not be too tight or too loose to expose inappropriate skin.
3. Only Lee University or plain, tee-shirts or collared “polo” style shirts in neutral or school colors are permitted during all clinical and field experiences.

4. Sweatshirts must follow the same criteria as shirts.

5. Shirts must be clean, wrinkle free, and not overly “worn”.

**Bottoms:**

1. Slacks and shorts should be a neutral or school color of navy, maroon, khaki, gray, white, or black.

2. Jeans and cut-offs are not allowed during all clinical and field experiences.

3. Team warm-ups and wind suits are permissible except for competition events.

4. Yoga pants are not permissible, but “exercise” pants will be approved on a case by case basis by your preceptor.

5. Professional skirts or dresses are not appropriate for field experiences.

6. Shorts must be of sufficient length determined by your preceptor.

7. All shorts and pants must be clean, wrinkle free, not overly worn, and not too tight to be deemed unprofessional.

**Footwear and Hats:**

1. Footwear should be athletic or casual. All shoes should be fully enclosed.

2. High heels are not acceptable.

3. Footwear should be appropriate to respond to an emergency situation or demonstrate functional, rehabilitative activity.

4. During competition, hats must be LU, LU athletics, or a plain neutral color with no logo other than manufacturer.

5. If wearing a hat, it must be work in the traditional manner.

6. Hats are only permitted indoors if the individual will be covering an outdoor event that day.

7. “Beanie” or “toboggan” hats are permissible when outside in cold weather.
Other:

1. Wear provided name badges with respective student-level designations during all clinical experiences. Freshman have white or no color, sophomores are yellow, juniors are blue, and seniors are green.
2. A professional, clean cut appearance is expected.
3. Students are expected to be compliant in dress code if engaged in any clinical education lasting longer than 5-10 minutes.
4. Students will not be permitted to obtain “clinical hours” if not in dress code.

PERSONAL CELLULAR TELEPHONES

Personal telephones are not to be used during clinical education and field assignments.

Occasionally circumstances dictate that the student might need to be contacted by cell phone.

When these situations arise, place the phone ringer in the silent or vibrate mode.
STUDENT HEALTH POLICY

And in so much as Athletic Training emphasizes by example and knowledge base the prevention, assessment, and rehabilitation of health and activity-limiting injuries or illnesses, the admissions committee recommends and requires adherence to and documentation of specific health standards and monitoring policies. As recommended or required by Lee University Undergraduate Programs, Tennessee State Health Law as well as certain other state regulatory health statutes the health policy for entering ATS will include: (all admitted athletic training students will comply with the following)

1. State of Tennessee requires all students born after 1956 to provide documentation of MMR immunization (measles, mumps, rubella) by two live measles vaccinations sometime after 12 months of age, unless medically contraindicated (i.e., allergy to immunization, pregnancy, or other medical reasons).

2. Lee University requires proof of Tuberculin (PPD) skin test within two year period prior to admission or documentation of adequate treatment for TB.

3. These verifications or documentations must have been done and signed by a licensed health care provider and copies made available to the Program Director. Upon the student’s signed permission, copies will be provided to the Lee University Health Services for their health file.

4. Entry into the ATEP program will be made on an individual basis after completion of all application requirements. This will include successful completion of pre-participation physical examination to delineate physical requirements (if any limitations are suspected), limitations and reasonable accommodations of the student in their day to day learning and responsibilities while in the program. These requirements will be in compliance with the “Technical Standards” as well as the “Communicable Disease Standards”.

5. This initial pre-participation physical examination is done (if necessary due to severe previous medical history) on an athletic training student upon acceptance into the Lee University ATEP curriculum of study. Successful completion of this physical exam will delineate any physical impairment which might require reasonable accommodations for that student. Since both the learning and the safety of the student are important in the consideration of reasonable accommodations; the admission ATEP committee will use the university director of academic support (La-Juan Stout) for final determination of limitations, accommodations or elimination from the program. These may include but not be limited to: physical impairment such as severe visual, hearing or motor impairment, acute or chronic medical condition limiting physical participation, presence of communicable disease, or mental impairments that may be determined
to severely limit the student’s ability to fully participate in the academic and clinical educational program.

6. Verification of completion of OSHA’s requirements for health care workers (HEW) in the work place. This is required since athletic training students will occasionally be exposed to blood/body fluid contamination while fulfilling the educational requirements of the Athletic Training Education Program. Topics will include an orientation course review concerning blood-borne pathogen exposures and medical-legal confidentiality requirements for the study of athletic training.

7. Lee University and Athletic Training Education Program are committed to the safe and healthy environment of a drug free workplace. The use or abuse of dependency producing drugs especially controlled substances is outlined in Controlled Substance Act, 21 USC Sec. 812. This we on admission council of Lee University Athletic Training Education Program have made available student drug abuse prevention program through Lee Health and Counseling Services. Further, athletic training students are equally subject to the code of conduct pertaining to use or possession of controlled, abusive substances and recipients of certain federal financial assistance programs (i.e. Pell Grants) are required to certify them drug free.

8. As a commitment to the safety and health of the athletic training student and staff, all admitted students are highly advised to show proof of completion of the Hepatitis A and B three part vaccination series. These immunizations are made available at cost through Lee University Health Services. All students that are admitted into the program must complete and submit to the Program Director the Hepatitis A and B Immunization Form (See Appendix P).

9. Infections are a normal response of the immune system defending the body from foreign microorganisms. These may include viral, bacterial, fungal, or parasitic infections. ATEP students who believe that they are experiencing an infectious illness which may include: upper and lower respiratory infections such as sore throat with fever, sinusitis, bronchitis or influenza with cough and coryza or gastrointestinal infections such as vomiting or diarrhea illnesses, hepatitis, mononucleosis or skin infections and infestations such as chicken pox, spider or mosquito bite which look irritated, must see a physician or nurse practitioner who should make the decision to allow or limit that student from any class or clinic activity.

Communicable diseases are listed in the following websites as a reference.
http://www.cdc.gov/
These measures are taken to protect both the sick student as well as protect their fellow students, athletes and staff from unnecessary exposure to communicable infections. A list of preventable behaviors for limiting infections both in ATEP students as well as athletes follows:

- Appropriate diet and sleep
- Proper skin care and hygiene especially care of infected skin lesions
- Prompt cleaning and covering of open wounds
- Personal protective equipment and enforcing of hand washing
- Immunization updates and confirmation
- Avoid contaminated water
CLINICAL EDUCATION IN THE
ATHLETIC TRAINING EDUCATION PROGRAM
@ LEE UNIVERSITY
Clinical education represents the athletic training students' formal acquisition, practice, and preceptor evaluation of the Entry-Level Athletic Training Clinical Proficiencies through classroom, laboratory, and clinical education experiences under the direct supervision of a preceptor. Formal evaluation of the application and integration of clinical proficiencies are completed by a preceptor and may be in conjunction with additional clinical instructors.

Related to clinical education is field experience, in which students have the opportunity to practice clinical proficiencies under the supervision of a preceptor. Observational clinical education at Lee University occurs prior to acceptance into ATEP. This observational period occurs while the student is a freshman and the fall semester as a sophomore, typically. During this period students must have OSHA training, however, their access to patients is very limited. The hand-on clinical portion for students begins after they are accepted into ATEP and in a minimum period of two and a half academic years (5 semesters) and is associated with course credit. Typically the observational period occurs during the students' first three semesters. Courses shall include academic syllabi that contain measurable educational objectives and specific clinical proficiency outcomes that can be documented over time.

Clinical supervision is defined by constant visual and auditory interaction between the student and the preceptor. This policy of instructor supervision is a must and should be maintained in all occasions, without exceptions. Students will not be allowed to work in any sport or facility without direct supervision. Students should arrive early to assist with stretching and will assist after events when warranted. Students are discouraged to travel with teams unless the preceptor is accompanying the student. Students are not used to replace clinical staff at any time. A Preceptor must accompany all events in which students are allowed to participate as ATS.

Once admitted to the ATEP program each ATS will accrue approximately 100 hours during their sophomore semester and 200 hours each semester thereafter until graduation.
(see Appendix O, clinical supervisor log). Hours are accrued at each clinical site with the Preceptor. The ATS should not accumulate more than 20 hours per week except during semester breaks. These 200 hours are necessary for the student to have ample opportunity to practice as well as be evaluated on performances related to academic success. Although the program is proficiency based and does not require “hours”, some states have specific clinical hours to be accumulated in order to become state licensed. Students are required to log supervised hours.

**Purpose of Clinical Education**

It is the purpose of the Lee University Athletic Training Education Program (ATEP) to be a functional educational and service facility for the Department of Health, Exercise Science, and Secondary Education. The program will endeavor to enhance the health care for the university’s intercollegiate athletes as well as the broader habitually active community of the university. The program will service the college community by endeavoring to help its members attain higher levels of performance through proper health care and appropriate efforts to prevent injury and illness. Clinical Education is the bridge in which students affectively learn to utilize the various skill development taught in the classroom. This is a vital component to student learning.

The ATEP will establish and maintain a corps of athletic training students that will be trained in the knowledge and skills that are essential to an entry-level athletic trainer. The purpose of clinical education is multidimensional. The student will:

1. Utilize clinical experiences for peer practice, skill acquisition, and skill development
2. Interact with many differing health care professionals, each having separate philosophies & experiences that will provide students with innovative skills that will enhance student development
3. Written and verbal communication through peer teaching, clinical documentation, and professional interactions.
4. Gain confidence in self by practicing skills under direct supervision of allied health professionals (e.g. Certified Athletic Trainers, Orthopaedic Surgeons, Physician Assistants, Physical Therapist & Nurses)
5. Accumulate many hours in field settings where critical thinking and problem solving will occur on a daily basis

6. Develop a mentorship with clinical instructors in order to foster a professional code of conduct that reflects Christian commitment

At the completion of the program, the athletic training student should be able to function as a health care professional with minimal supervision in an allied health care setting and be eligible to sit for the BOC certification examination.

**Instruction of Clinical Proficiencies and Clinically Integrated Proficiencies**

The goal of Clinical Education is to facilitate a student’s ability to utilize the cognitive knowledge, psychomotor skills, and clinical abilities with behaviors of professional practice, which demonstrate a level of practice which is appropriate for an entry level certified athletic trainer. Clinical education is organized by lecture, lab, and clinical experience. These elements are taught overtime with consistent feedback provided to each student. The content taught is outlined in *Athletic Training Educational Competencies* (5th ed., 2011). The Clinically Integrated Proficiencies published by NATA are Lee University’s guide for the common set of skills that an entry-level athletic trainer should possess. Proficiencies also define the expectations of an outcome based clinical education system. Clinical proficiencies and psychomotor competencies will be introduced and instructed during coursework. The skills are taught, demonstrated, practiced, and then evaluated in at least two settings, demonstrating learning over time. Documentation of these skill sets will occur on the proficiency signature pages.

Learning over time is the documented continuous process of skill acquisition, progression, and student reflection. It involves the demonstration of systematic progression through the cognitive, psychomotor, and clinical proficiencies within different contextual environments (e.g., athletic training room, practice field, etc.). Assessment of learning over time is built around multiple indicators and sources of evidence such as observations (student affective behaviors, interviews); performance samples (clinical skill demonstration); and tests or test-like procedures. Learning over
time will be demonstrated through proficiency evaluations during the academic and clinical experiences. Preceptors are given the appropriate evaluation tools for a clinical review. Classroom laboratory examinations or classroom instructor proficiencies will be more in depth and will allow the student appropriate one-on-one interaction. All ATS will be assigned to a specific preceptor for each rotation. All preceptor evaluations will be conducted in a one-on-one situation. Each student will be responsible for obtaining two peer evaluations on psychomotor skills prior to engaging the preceptor or classroom instructor for a formal evaluation on skill development.

Affiliated Sites

An athletic training student’s primary clinical experiences will be on the Lee University campus. The ATEP will utilize off-campus rotations, such as football and other diversified experiences, to enhance the clinical education and field experiences of athletic training students. The campus health clinic plays an important role when students begin learning general medical conditions as they relate to the well-being of physically active individuals. Off-campus sites listed below are utilized to provide educational experience in a non-traditional environment. These rotations are designed to enhance the upper and lower extremity and general medical experiences. The physician assistants, physical therapists, occupational therapists, and certified athletic trainers supervise, instruct, and guide students through clinical education experiences. Grace Academy, McCallie, Cleveland, Walker Valley, and Ooltewah High Schools will provide students with experience in an equipment intensive, high-risk environment through sports such as football and wrestling. (See Appendix R for individual site policies and procedures.) Students are responsible for transportation to and from clinical sites and all costs incurred. The following traveling distances from Lee University to clinical sites are approximated:

- Benchmark Physical Therapy – 1 mile
- Ooltewah High School – 15 miles
- Center for Sports Medicine and Orthopaedics in Chattanooga – 28 miles
- Center for Sports Medicine and Orthopaedics in Cleveland – 1 mile
- McCallie High School – 28 miles
- North River Physical Therapy – 30 miles
- Cleveland High School – 2.5 miles
Rotation of Students for Clinical Sites and Field Experiences

Students are assigned to a specific preceptors or supervisor, not to a facility or sport. Clinical rotations during the sophomore and junior years will last approximately five weeks, and seniors will be assigned a specific preceptor for the entire season of competition. Each student will gain experience in four general areas: Upper extremity, lower extremity, equipment intensive, and general medical. An overall emphasis on high-risk sports will foster student learning. Placement of students in Clinical Rotations is based in part on the following considerations:

- Classroom preparation
- Clinical preparation
- Performance evaluations in both classroom and clinical rotations
- Professionalism
- Educational needs

Examples of Each of the Clinical Emphases:

**Upper extremity**
- Men’s tennis
- Women’s tennis
- Men’s baseball
- Women’s softball
- Women’s volleyball

**Lower extremity**
- Men’s cross country
- Women’s cross country
- Men’s basketball
- Women’s basketball
- Men’s soccer
- Women’s soccer

**General Medical**
- Lee University Health Clinic
- Lee University Athletic Training Room

**Equipment Intensive**
- High school athletics
- Intercollegiate athletics

Guidelines for the Clinical Education of Lee University Students:

*Description* The student’s clinical experience is composed of two elements: Clinical Education and Field Experience. The clinical education component involves the acquisition and practice of clinical skills. The field experience provides the student with the opportunity to apply these skills in the clinical environment (i.e., the athletic training...
room, practice/game coverage). Both educational experiences will be supervised by a preceptor.

**Clinical Education Supervision**

An ACI or a CI, as defined in the subsequent section, will at all times supervise the students’ clinical education. “Supervision” of students by the ACI or CI is defined in our program as, “constant visual and auditory interaction between the student and the approved clinical instructor”. Students are assigned to an instructor, not to facilities or sports. The daily supervision of students by the preceptor allows for multiple opportunities for evaluation and feedback between the student and approved clinical instructor. Students are permitted to develop proficiency within adjunct affiliated professional clinical sites (e.g., hospital emergency rooms, clinics, exercise physiology labs) during the clinical education course or experience. These experiences, however, do not comprise the majority of the student’s clinical experience.

Lee University Approved Clinical Instructors and Clinical instructors change periodically and are currently listed on our academic administrative structure (Appendix A). Training for preceptors occurs every three years; however, yearly group meetings will ensure adequate communication toward ongoing program improvement.

**Field Experience Overview**

The primary settings for the students’ clinical education and field experiences should include athletic training room(s), athletic team practices, and competitive events. The athletic training room is considered to be “a designated physical facility where comprehensive health care services are provided.” Comprehensive health care services
include practice and game preparation, injury/illness evaluation, first aid and emergency care, follow-up care, rehabilitation, and related services.

Ample opportunity is provided for student coverage of athletic practices and competitive events in a variety of men’s and women’s sports, including high-risk sport activities. These experiences also include adequate opportunities for observation of, and involvement in, the immediate management and emergency care of a variety of acute athletic injuries and illnesses. Practitioner competencies should provide the basis for deriving the objectives and activities constituting the program’s curriculum. Both program competencies and curriculum objectives should be consistent with the stated level of practitioner preparation. The level is delineated in the program’s goals and objectives statements and encompasses the knowledge, skill, and behavior expected of graduates upon entry into the field.

Supervised field experiences involve personal/verbal contact at the site of supervision between the athletic training student and the certified athletic trainer, who plans, directs, advises, and evaluates the student’s athletic training field experience. The supervising certified athletic trainer is always on-site where the athletic training experience is being obtained.

Clinical supervisors are readily accessible to students for on-going feedback and guidance on a daily basis. Certified athletic trainers who are supervising athletic training students’ experiences shall afford supervision adequate to assure (following stated written
and verbal direction) that the student performs his or her tasks in a manner consistent with the Standards of Practice of the profession of Athletic Training.

**Clinical Education Summary**

The student’s clinical education course, field experiences, or a combination of the two should provide exposure of the student to specific populations, establishing adequate learning environments.

The Athletic Training Educational Competencies abide by the *Standards for the Accreditation of Entry-Level Educational Programs for the Athletic Trainer* (CAATE). Standards can be found in Appendix E.

Our clinical education plan seeks to foster learning over time. Repetition is a key component in the learning process. A sampling of proficiencies and clinically integrated proficiencies are provided in the Clinical Proficiency (CP) Profile pages to follow. The CP signature pages represent a snapshot of the intended courses in which a student will be evaluated initially, and then again, on each proficiency and clinically integrated proficiency.
Clinical Proficiencies Profile

Pre-Professional Level/ Sophomore Year
Yellow name badge

ATEP 115  Basic Concepts of Fitness
ATEP 199  Introduction to Athletic Training Profession
ATEP 200  Care and Prevention
ATEP 201  Pre- Professional Practicum
ATEP 353  First-Aid and CPR for the Professional Rescuer

Level I / Junior Year
Blue name badge

ATEP 300  Practicum I
ATEP 310  Orthopaedic Evaluation I (Lower Extremity)
ATEP 370  Therapeutic Modalities

Level 2 / Junior Year
Blue name badge

ATEP 301  Practicum II
ATEP 311  Orthopaedic Evaluation II (Upper Extremity)
ATEP 380  Therapeutic Exercise
ATEP 312  Physical Assessment

Level 3 / Senior Year
Green name badge

ATEP 400  Practicum III
ATEP 460  Supervision and Administration

Level 4 / Senior Year
Green name badge

ATEP 401  Practicum IV
ATEP 391  Pharmacology
# Basic Concepts of Fitness ATEP 115

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**Range of motion testing (AROM, PROM, RROM)**

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**Body composition and somatotyping**

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<td>Hip spica (hip flexor)</td>
<td>245</td>
<td>300</td>
</tr>
<tr>
<td>4/15</td>
<td>Hip spica (adductor)</td>
<td>246</td>
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<tr>
<td>4/15</td>
<td>Knee compression wrap</td>
<td>247</td>
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<tr>
<td>4/27</td>
<td>Casting</td>
<td>247</td>
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### Acute Care & Prevention

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure</th>
<th>Citation</th>
<th>ATEP</th>
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<tbody>
<tr>
<td>3/18</td>
<td>Heat Index</td>
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<td>200</td>
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<tr>
<td>3/18</td>
<td>Sling psychrometer</td>
<td>14</td>
<td>200</td>
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<tr>
<td>4/27</td>
<td>Rom and Muscles of foot &amp; ankle</td>
<td></td>
<td>200</td>
</tr>
<tr>
<td>4/27</td>
<td>Rom and Muscles of knee</td>
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<tr>
<td>4/27</td>
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<td>Rom and Muscles of elbow and wrist</td>
<td></td>
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<tr>
<td>4/15</td>
<td>Tripod Non-weight bearing</td>
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<tr>
<td>4/15</td>
<td>Stair climbing Non-weight bearing</td>
<td>11</td>
<td>300</td>
</tr>
<tr>
<td>4/15</td>
<td>Crutch fitting</td>
<td>9</td>
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### Communication and Documentation

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<tbody>
<tr>
<td>4/20</td>
<td>Assist with logging patient notes</td>
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<tr>
<td>4/20</td>
<td>Mock Communication with coach &amp; athlete</td>
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### Training

<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>4/22</td>
<td>Flexibility for Upper &amp; Lower Body</td>
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<tr>
<td>4/22</td>
<td>Upper &amp; Lower Body Strength</td>
<td>341</td>
<td>115</td>
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<tr>
<td>4/22</td>
<td>Lumbar &amp; Cervical Region Strength</td>
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<tr>
<td>4/22</td>
<td>Lower &amp; Upper Body Endurance Program</td>
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<tr>
<td>4/22</td>
<td>Lower &amp; Upper Body Speed Program</td>
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<tr>
<td>4/22</td>
<td>Lower &amp; Upper Body Power Program</td>
<td></td>
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</tr>
<tr>
<td>1/28</td>
<td>Demonstrate Proper Lifting Technique</td>
<td>319</td>
<td>115</td>
</tr>
<tr>
<td>1/28</td>
<td>Demonstrate Proper Spotting Technique</td>
<td>320</td>
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### Protective Equipment

<table>
<thead>
<tr>
<th>Date</th>
<th>Equipment</th>
<th>Citation</th>
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<tbody>
<tr>
<td>2/25</td>
<td>Football helmet &amp; head gear</td>
<td>257</td>
<td>200</td>
</tr>
<tr>
<td>2/25</td>
<td>Football Pads</td>
<td>262</td>
<td>200</td>
</tr>
<tr>
<td>2/25</td>
<td>Mouth Guard</td>
<td>263</td>
<td>200</td>
</tr>
</tbody>
</table>
1. Plan, implement, evaluate, and modify a fitness program specific to the physical status of the patient. This will include instructing the patient in proper performance of the activities and the warning signs and symptoms of potential injury that may be sustained. Effective lines of communication shall be established to elicit and convey information about the patient’s status and the prescribed program. While maintaining patient confidentiality, all aspects of the fitness program shall be documented using standardized record-keeping methods.

<table>
<thead>
<tr>
<th>Date</th>
<th>Service Description</th>
<th>Score</th>
<th>Instructor Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/25</td>
<td>Facemask Removal</td>
<td>261</td>
<td>ATEP 200</td>
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<tr>
<td>2/25</td>
<td>Hardshell Doughnut Pad</td>
<td>260</td>
<td>ATEP 200</td>
</tr>
<tr>
<td>2/25</td>
<td>Shoe Fitting</td>
<td>268</td>
<td>ATEP 200</td>
</tr>
<tr>
<td>2/25</td>
<td>Knee &amp; Ankle Bracing</td>
<td>269 270</td>
<td>ATEP 200</td>
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**Therapeutic Modalities**

<table>
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<th>Service Description</th>
<th>Score</th>
<th>Instructor Code</th>
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<tbody>
<tr>
<td>2/25</td>
<td>Cold Whirlpool</td>
<td>405</td>
<td>ATEP 370</td>
</tr>
<tr>
<td>2/25</td>
<td>Ice Massage</td>
<td>409</td>
<td>ATEP 370</td>
</tr>
<tr>
<td>2/25</td>
<td>Ice bag/commercial pack</td>
<td>400</td>
<td>ATEP 370</td>
</tr>
<tr>
<td>2/25</td>
<td>Hot Whirlpool</td>
<td>413</td>
<td>ATEP 370</td>
</tr>
<tr>
<td>2/25</td>
<td>Moist heat pack</td>
<td>401</td>
<td>ATEP 370</td>
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---

**Brief Description:**

The CP was performed accurately and in the appropriate order. The student showed professionalism while performing the task. The student had an effective communication with the patient. The student demonstrated proper documentation. The student established a proper follow up plan.

**Pass = 75% of the overall score**

Circle: Fail / Pass

**Comments:**

**Overall evaluation**

<table>
<thead>
<tr>
<th>NP</th>
<th>F</th>
<th>P</th>
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<tbody>
<tr>
<td>NP</td>
<td>F</td>
<td>P</td>
</tr>
<tr>
<td>NP</td>
<td>F</td>
<td>P</td>
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</tbody>
</table>
# Practicum I ATEP 300

<table>
<thead>
<tr>
<th>Taping &amp; Casting</th>
<th>First Evaluation</th>
<th>Second Evaluation</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Citation</td>
<td>Preceptor signature</td>
</tr>
<tr>
<td>McConnel Taping</td>
<td>206,207*</td>
<td>ATEP 201</td>
</tr>
<tr>
<td>Shoulder spica (GH) elastic wrap</td>
<td>239</td>
<td>ATEP 201</td>
</tr>
<tr>
<td>AC spica taping</td>
<td>240</td>
<td>ATEP 201</td>
</tr>
<tr>
<td>Shoulder spica (AC) elastic wrap</td>
<td>241</td>
<td>ATEP 201</td>
</tr>
<tr>
<td>Hip Spica (flexor)</td>
<td>245</td>
<td>ATEP 201</td>
</tr>
<tr>
<td>Hip spica (adductor)</td>
<td>246</td>
<td>ATEP 201</td>
</tr>
<tr>
<td>Knee compression wrap</td>
<td>247</td>
<td>ATEP 353</td>
</tr>
<tr>
<td>Casting</td>
<td></td>
<td>ATEP 201</td>
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## Clinical Measurements and Treatments

<table>
<thead>
<tr>
<th></th>
<th>First Evaluation</th>
<th>Second Evaluation</th>
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</thead>
<tbody>
<tr>
<td>Spine boarding</td>
<td>295-298*</td>
<td>ATEP 353</td>
</tr>
<tr>
<td>Radial and carotid pulse &amp; BP</td>
<td>272,273</td>
<td>ATEP 353</td>
</tr>
<tr>
<td>Auscultation skills of the heart</td>
<td>275</td>
<td>ATEP 312</td>
</tr>
<tr>
<td>Auscultation skills of the lungs</td>
<td>276</td>
<td>ATEP 312</td>
</tr>
<tr>
<td>Respiration assessment</td>
<td>278</td>
<td>ATEP 353</td>
</tr>
<tr>
<td>Otoscope Use</td>
<td>280</td>
<td>ATEP 312</td>
</tr>
<tr>
<td>Tympanic/oral thermometer</td>
<td>281,282</td>
<td>ATEP 312</td>
</tr>
<tr>
<td>Use of fluorescein ophthalmic strips</td>
<td></td>
<td>ATEP 312</td>
</tr>
<tr>
<td>Use of ultraviolet light in eye &amp; skin</td>
<td></td>
<td>ATEP 312</td>
</tr>
<tr>
<td>Ophthalmoscope</td>
<td>283</td>
<td>ATEP 312</td>
</tr>
<tr>
<td>Pupillary/Consensual reaction test</td>
<td>284,285</td>
<td>ATEP 353</td>
</tr>
<tr>
<td>Eye motility-tracking</td>
<td>286</td>
<td>ATEP 353</td>
</tr>
<tr>
<td>Snellen eye chart</td>
<td>287</td>
<td>ATEP 312</td>
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<tr>
<td>Urinalysis dipstick</td>
<td>288,289</td>
<td>ATEP 312</td>
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## Protective Devices

<table>
<thead>
<tr>
<th></th>
<th>First Evaluation</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Sling &amp; swath</td>
<td>258</td>
<td>ATEP 353</td>
</tr>
<tr>
<td>Finger splint</td>
<td>259</td>
<td>ATEP 353</td>
</tr>
<tr>
<td>Sam splint</td>
<td>264</td>
<td>ATEP 353</td>
</tr>
<tr>
<td>Knee immobilizer</td>
<td>265</td>
<td>ATEP 353</td>
</tr>
<tr>
<td>Vacuum splint for fractured tibia</td>
<td>267</td>
<td>ATEP 353</td>
</tr>
<tr>
<td>Tripod non-weight bearing</td>
<td>9,10</td>
<td>ATEP 201</td>
</tr>
<tr>
<td>Stair climbing Non-weight bearing</td>
<td>11</td>
<td>ATEP 201</td>
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## Nutrition

<table>
<thead>
<tr>
<th></th>
<th>First Evaluation</th>
<th>Second Evaluation</th>
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</thead>
<tbody>
<tr>
<td>Access and assess RDA or equivalent</td>
<td></td>
<td>ATEP 115</td>
</tr>
<tr>
<td>Assess protein, fat, &amp; CHO intake</td>
<td></td>
<td>ATEP 115</td>
</tr>
<tr>
<td>Assess Vitamin &amp; Mineral intake</td>
<td></td>
<td>ATEP 115</td>
</tr>
<tr>
<td>Calculate BMR, caloric intake, &amp; expenditure</td>
<td></td>
<td>ATEP 115</td>
</tr>
<tr>
<td>Provide nutritional information for active population of all ages</td>
<td></td>
<td>ATEP 301</td>
</tr>
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</table>

## Victim Assessment

<table>
<thead>
<tr>
<th></th>
<th>First Evaluation</th>
<th>Second Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey Scene &amp; collect medical history</td>
<td>AAOS</td>
<td>ATEP 353</td>
</tr>
<tr>
<td>AED</td>
<td>AAOS</td>
<td>ATEP 353</td>
</tr>
<tr>
<td>Airway management skills</td>
<td>AAOS</td>
<td>ATEP 353</td>
</tr>
<tr>
<td>Title</td>
<td>AAOS</td>
<td>ATEP 353</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>--------</td>
<td>----------</td>
</tr>
<tr>
<td>Circulation assessment skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact poison control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult, child, infant, two-man CPR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toxic overdose/recovery position</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Amheim Reference*

1. Select, apply, evaluate, and modify appropriate standard protective equipment and other custom devices for the patient in order to prevent and/or minimize the risk of injury to the head, torso, spine and extremities for safe participation in sport and/or physical activity. Effective lines of communication shall be established to elicit and convey information about the patient’s situation and the importance of protective devices to prevent and/or minimize injury.

| The CP was performed accurately and in the appropriate order. | NP | P |
| The student showed professionalism while performing the task. | NP | P |
| The student had an effective communication with the patient. | NP | P |
| The student demonstrated proper documentation. | NP | P |
| The student established a proper follow up plan. | NP | P |

*Pass = 75% of the overall score*  
*Circle: Fail / Pass*

2. Demonstrate the ability to manage acute injuries and illnesses. This will include surveying the scene, conducting an initial assessment, utilizing universal precautions, activating the emergency action plan, implementing appropriate emergency techniques and procedures, conducting a secondary assessment and implementing appropriate first aid techniques and procedures for non-life-threatening situations. Effective lines of communication should be established and the results of the assessment, management and treatment should be documented.

| The CP was performed accurately and in the appropriate order. | NP | P |
| The student showed professionalism while performing the task. | NP | P |
3. Demonstrate the ability to conduct an intervention and make the appropriate referral of an individual with a suspected substance abuse or other mental health problem. Effective lines of communication should be established to elicit and convey information about the patient’s status. While maintaining patient confidentiality, all aspects of the intervention and referral should be documented using standardized record-keeping methods.

| The student had an effective communication with the patient. | NP | P |
| The student demonstrated proper documentation. | NP | P |
| The student established a proper follow up plan. | NP | P |

*Pass = 75% of the overall score*  
*Circle:*  

| Comments: |
| Overall evaluation | Confidence | Skill | Efficiency |
| NP | NP | NP |

Brief Description:  

| Date(s): |
| The CP was performed accurately and in the appropriate order. | NP | P |
| The student showed professionalism while performing the task. | NP | P |
| The student had an effective communication with the patient. | NP | P |
| The student demonstrated proper documentation. | NP | P |
| The student established a proper follow up plan. | NP | P |

*Pass = 75% of the overall score*  
*Circle:*  

| Comments: |
| Overall evaluation | Confidence | Skill | Efficiency |
| NP | NP | NP |
4. Demonstrate the ability to counsel a patient in proper nutrition. This may include providing basic nutritional information and/or an exercise and nutrition program for weight gain or weight loss. The student will demonstrate the ability to take measurements and figure calculations for a weight control plan (e.g., measurement of body composition and BMI, calculation of energy expenditure, caloric intake, and BMR). Armed with basic nutritional data, the student will demonstrate the ability to develop and implement a preparticipation meal and an appropriate exercise and nutritional plan for an active individual. The student will develop an active listening relationship to effectively communicate with the patient and, as appropriate, refer the patient to other medical professionals (physician, nutritionist, counselor or psychologist) as needed.

<table>
<thead>
<tr>
<th>Brief Description:</th>
<th>Date(s):</th>
</tr>
</thead>
<tbody>
<tr>
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The CP was performed accurately and in the appropriate order.          NP |   P
The student showed professionalism while performing the task.        NP |   P
The student had an effective communication with the patient.        NP |   P
The student demonstrated proper documentation.                     NP |   P
The student established a proper follow up plan.                    NP |   P

*Pass = 75% of the overall score*

<table>
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Comments:

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<th>Skill</th>
<th>Efficiency</th>
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<tbody>
<tr>
<td>NP</td>
<td>NP</td>
<td>NP</td>
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</tbody>
</table>

5. Demonstrate the ability to recognize disordered eating and eating disorders, establish a professional helping relationship with the patient, interact through support and education, and encourage vocal discussion and other support through referral to the appropriate medical professionals.

<table>
<thead>
<tr>
<th>Brief Description:</th>
<th>Date(s):</th>
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<tbody>
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</table>

The CP was performed accurately and in the appropriate order.          NP |   P
The student showed professionalism while performing the task.        NP |   P
The student had an effective communication with the patient.        NP |   P
The student demonstrated proper documentation.                     NP |   P
The student established a proper follow up plan.                    NP |   P

*Pass = 75% of the overall score*

<table>
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<td>Confidence</td>
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| NP | | P |
| NP | | P |
| NP | | P |

50
<table>
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<tr>
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<th>First Evaluation</th>
<th>Second Evaluation</th>
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<tbody>
<tr>
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<td>Preceptor signature</td>
</tr>
<tr>
<td>Ankle/Foot Assessment</td>
<td>2/5 History</td>
<td>ATEP 310</td>
</tr>
<tr>
<td></td>
<td>2/5 Observation/Inspection</td>
<td>ATEP 310</td>
</tr>
<tr>
<td></td>
<td>2/5 Bony &amp; soft tissue palpation</td>
<td>ATEP 310</td>
</tr>
<tr>
<td></td>
<td>2/5 AROM/PROM</td>
<td>ATEP 310</td>
</tr>
<tr>
<td></td>
<td>2/5 MMT (grades 0-5)</td>
<td>112-124</td>
</tr>
<tr>
<td></td>
<td>2/5 Ligamentous test</td>
<td>32-35</td>
</tr>
<tr>
<td></td>
<td>2/5 Special test</td>
<td>195-199</td>
</tr>
<tr>
<td>Knee Assessment</td>
<td>2/5 History</td>
<td>ATEP 310</td>
</tr>
<tr>
<td></td>
<td>2/5 Observation/Inspection</td>
<td>ATEP 310</td>
</tr>
<tr>
<td></td>
<td>2/5 Bony &amp; soft tissue palpation</td>
<td>ATEP 310</td>
</tr>
<tr>
<td></td>
<td>2/5 AROM/PROM</td>
<td>ATEP 310</td>
</tr>
<tr>
<td></td>
<td>2/5 MMT (grades 0-5)</td>
<td>107-11,114-115</td>
</tr>
<tr>
<td></td>
<td>2/5 Ligamentous test</td>
<td>36-48</td>
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<td>2/5 Special test</td>
<td>200-208</td>
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<td>Patellofemoral</td>
<td>2/5 History</td>
<td>ATEP 310</td>
</tr>
<tr>
<td></td>
<td>2/5 Observation/Inspection</td>
<td>ATEP 310</td>
</tr>
<tr>
<td></td>
<td>2/5 Bony &amp; soft tissue palpation</td>
<td>ATEP 310</td>
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<tr>
<td></td>
<td>2/5 Ligamentous test</td>
<td>ATEP 310</td>
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<tr>
<td></td>
<td>2/5 Manual muscle testing</td>
<td>107-11,114-115</td>
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<tr>
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<td>2/5 Special test</td>
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</tr>
<tr>
<td>Hip Assessment</td>
<td>2/8 History &amp; inspection</td>
<td>ATEP 310</td>
</tr>
<tr>
<td></td>
<td>2/8 bony palpation</td>
<td>ATEP 310</td>
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<td></td>
<td>2/8 soft tissue palpation</td>
<td>ATEP 310</td>
</tr>
<tr>
<td></td>
<td>2/8 AROM/PROM</td>
<td>ATEP 310</td>
</tr>
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<td>2/8 MMT (grades 0-5)</td>
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<td>2/8 special test</td>
<td>ATEP 310</td>
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<tr>
<td></td>
<td>2/8 Other tests</td>
<td>ATEP 310</td>
</tr>
<tr>
<td>Thoracic &amp; Low Back Assessment</td>
<td>2/20 History &amp; inspection</td>
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<tr>
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1. Demonstrate the ability to develop, implement, and communicate effective policies and procedures to allow safe and efficient physical activity in a variety of environmental conditions. This will include obtaining, interpreting, and recognizing potentially hazardous environmental conditions and making the appropriate recommendations for the patient and/or activity. Effective lines of communication shall be established with the patient, coaches and/or appropriate officials to elicit and convey information about the potential hazard of the environmental condition and the importance of implementing appropriate strategies to prevent injury.

**Brief Description:**

The CP was performed accurately and in the appropriate order. The student showed professionalism while performing the task. The student had an effective communication with the patient. The student demonstrated proper documentation. The student established a proper follow up plan.

- **Pass = 75% of the overall score**
  - **Circle:** Fail / Pass

**Comments:**

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2. Demonstrate a musculoskeletal assessment of upper extremity, and head/face, for the purpose of identifying (a) common acquired or congenital risk factors that would predispose the patient to injury and (b) a musculoskeletal injury. This will include identification and recommendations for the correction of acquired or congenital risk factors for injury. At the conclusion of the assessment, the student will diagnose the patient’s condition and determine and apply immediate treatment and/or referral in the management of the condition. Effective lines of communication should be established to elicit and convey information about the patient's status. While maintaining patient confidentiality, all aspects of the assessment should be documented using standardized record-keeping methods.

**Brief Description:**

The CP was performed accurately and in the appropriate order. The student showed professionalism while performing the task. The student had an effective communication with the patient. The student demonstrated proper documentation. The student established a proper follow up plan.

- **NP**
Pass = 75% of the overall score

Circle: Fail / Pass

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3. Demonstrate a general and specific (e.g., head, torso and abdomen) assessment for the purpose of (a) screening and referral of common medical conditions, (b) treating those conditions as appropriate, and (c) when appropriate, determining a patient's readiness for physical activity. Effective lines of communication should be established to elicit and convey information about the patient's status and the treatment program. While maintaining confidentiality, all aspects of the assessment, treatment, and determination for activity should be documented using standardized record-keeping methods.

**Brief Description:**

(e.g. derma, brain injury, thorax (heart & lung), abdomen (organs, renal, urogenital), eyes, ears, nose, & throat)

The CP was performed accurately and in the appropriate order.

The student showed professionalism while performing the task.

The student had an effective communication with the patient.

The student demonstrated proper documentation.

The student established a proper follow up plan.

**Pass = 75% of the overall score**

**Comments:**

Overall evaluation

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4. Synthesize information obtained in a patient interview and physical examination to determine the indications, contraindications and precautions for the selection, patient set-up, and evidence-based application of therapeutic modalities for acute and chronic injuries. The student will formulate a progressive treatment and rehabilitation plan and appropriately apply the modalities. Effective lines of communication should be established to elicit and convey information about the patient's status and the prescribed modality(s). While maintaining patient confidentiality, all aspects of the treatment plan should be documented using standardized record-keeping methods.

**Brief Description:**

The CP was performed accurately and in the appropriate order.

The student showed professionalism while performing the task.

The student had an effective communication with the patient.

The student demonstrated proper documentation.

The student established a proper follow up plan.

**Pass = 75% of the overall score**
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<td>Clinical symptoms of head/neck injuries</td>
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<td>Clinical signs/symptoms asthma</td>
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<td>ID, Inspection &amp; palpation of abnormalities of bones &amp; joints</td>
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**Body Composition and Somatotyping**

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<td>Weight/BMI</td>
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<td>Body composition (skinfold, BIA)</td>
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<td>Classifying body types</td>
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* O’Conner Text
# First-Aid & CPR for the PR ATEP 353 L

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<th>Survey Scene/initiate EAP</th>
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<td>Radial/carotid pulse</td>
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<td>Evacuation skills/Transport off field of play</td>
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<td>Drug Overdose (contact poison control, recovery positioning)</td>
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<td>Sam splint</td>
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<td>Utilize tracking system for Meds</td>
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<td>Use PDR</td>
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<td>Use P &amp; P to give OTC meds</td>
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<td>ATEP 401</td>
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<td>Practice epinephrine injections</td>
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Obtain and communicate patient education concerning a variety of medicines:

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*Principles of Pharmacology

**Principles of Pharmacology for AT
# Practicum III ATEP 400

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1. Demonstrate a musculoskeletal assessment of lower extremity and spine (including the ribs) for the purpose of identifying (a) common acquired or congenital risk factors that would predispose the patient to injury and (b) a musculoskeletal injury. This will include identification and recommendations for the correction of acquired or congenital risk factors for injury. At the conclusion of the assessment, the student will diagnose the patient’s condition and determine and apply immediate treatment and/or referral in the management of the condition. Effective lines of communication should be established to elicit and convey information about the patient’s status. While maintaining patient confidentiality, all aspects of the assessment should be documented using standardized record-keeping methods.

The CP was performed accurately and in the appropriate order.

The student showed professionalism while performing the task.

The student had an effective communication with the patient.

The student demonstrated proper documentation.

The student established a proper follow up plan.

Pass = 75% of the overall score

Comments:

Overall evaluation

Confidence

Skill

Efficiency

2. Synthesize information obtained in a patient interview and physical examination to determine the indications, contraindications and precautions for the selection, application, and evidence-based design of a therapeutic exercise program for injuries to the upper extremity, lower extremity, trunk, and spine. The student will formulate a progressive rehabilitation plan and appropriately demonstrate and/or instruct the exercises and/or techniques to the patient. Effective lines of communication...
should be established to elicit and convey information about the patient’s status and the prescribed exercise(s). While maintaining patient confidentiality, all aspects of the exercise plan should be documented using standardized record-keeping methods.

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<td>(e.g. ROM, strength, endurance, speed, power, balance, NM, coordination, agility, cardio, sport skills, work skills)</td>
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The CP was performed accurately and in the appropriate order.  
NP | P

The student showed professionalism while performing the task.  
NP | P

The student had an effective communication with the patient.  
NP | P

The student demonstrated proper documentation.  
NP | P

The student established a proper follow up plan.  
NP | P

Pass = 75% of the overall score  
Circle:  Fail / Pass

Comments:
Overall evaluation  Confidence  Skill  Efficiency  
NP | P  NP | P  NP | P

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**Lower Extremity exercise**

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**Upper Extremity exercise**

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<td>Upper body &amp; lower body 338,356</td>
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### Miscellaneous

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<td>Demonstrate appropriate patient instruction</td>
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<td>Return to play criteria 339,357</td>
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<td>High school presentation</td>
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3. Demonstrate the ability to select and integrate appropriate motivational techniques into a patient’s treatment or rehabilitation program. This includes, but is not limited to, verbal motivation, visualization, imagery, and/or desensitization. Effective lines of communication should be established to elicit and convey information about the techniques. While maintaining patient confidentiality, all aspects of the program should be documented using standardized record-keeping techniques.

**Brief Description:**

| The CP was performed accurately and in the appropriate order. | NP | P |
| The student showed professionalism while performing the task. | NP | P |
| The student had an effective communication with the patient. | NP | P |
| The student demonstrated proper documentation. | NP | P |
The student established a proper follow up plan.  

| Pass = 75% of the overall score | Circle: Fail / Pass |

Comments:

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<td>ATC Licensure</td>
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<td>Develop budget based on needs (capital and operational)</td>
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<td>Critical Review of Literature</td>
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<td>4/16</td>
<td>Design, safe and efficient facility</td>
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<td>Comprehensive file management system for billing &amp; insurance</td>
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<td>Policy and Procedure (OTC, etc.)</td>
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<td>Use approp. references (PDR, etc.)</td>
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### Physical Assessment of Medical conditions

| 3/19  | blood sugar testing | 291   | ATEP 312 |
| 3/19  | abdominal rebound testing | ATEP 312 |                   |
| 3/21  | incision & drainage procedures | ATEP 312 |                   |
| 3/21  | soft tissue abscess I & D | ATEP 312 |                   |
| 3/21  | subungal hematoma drainage | ATEP 312 |                   |
| 3/19  | wart cryotherapy | ATEP 312 |                   |
| 3/19  | wart parring & I & D | ATEP 312 |                   |

### Professional Development

| 4/20  | Professional Lecture | ATEP 301.400 |                   |
| 4/20  | Professional Promotions | ATEP 301 |                   |

1. Plan, implement, evaluate, and modify a fitness program specific to the physical status of the patient. This will include instructing the patient in proper performance of the activities and the warning signs and symptoms of potential injury that may be sustained. Effective lines of communication shall be established to elicit and convey information about the patient’s status and the prescribed program. While maintaining patient confidentiality, all aspects of the fitness program shall be documented using standardized record-keeping methods.

**Brief Description:**

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The CP was performed accurately and in the appropriate order.

The student showed professionalism while performing the task.

The student had an effective communication with the patient.

The student demonstrated proper documentation.
The student established a proper follow up plan.  

Pass = 75% of the overall score  

Comments:  

Overall evaluation  

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<td>NP</td>
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2. Select, apply, evaluate, and modify appropriate standard protective equipment and other custom devices for the patient in order to prevent and/or minimize the risk of injury to the head, torso, spine and extremities for safe participation in sport and/or physical activity. Effective lines of communication shall be established to elicit and convey information about the patient’s situation and the importance of protective devices to prevent and/or minimize injury.

Brief Description:  

The CP was performed accurately and in the appropriate order.  

The student showed professionalism while performing the task.  

The student had an effective communication with the patient.  

The student demonstrated proper documentation.  

The student established a proper follow up plan.  

Pass = 75% of the overall score  

Comments:  

Overall evaluation  

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<td>NP</td>
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3. Demonstrate the ability to develop, implement, and communicate effective policies and procedures to allow safe and efficient physical activity in a variety of environmental conditions. This will include obtaining, interpreting, and recognizing potentially hazardous environmental conditions and making the appropriate recommendations for the patient and/or activity. Effective lines of communication shall be established with the patient, coaches and/or appropriate officials to elicit and convey information about the potential hazard of the environmental condition and the importance of implementing appropriate strategies to prevent injury.

Brief Description:  

The CP was performed accurately and in the appropriate order.  

The student showed professionalism while performing the task.  

Comments:  

Overall evaluation  

<table>
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<th>Confidence</th>
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### Task

The student had an effective communication with the patient.  

The student demonstrated proper documentation.  

The student established a proper follow up plan.  

*Pass = 75% of the overall score Circle: Fail / Pass*

### Comments:

### Overall evaluation

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The CP was performed accurately and in the appropriate order.  

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The student demonstrated proper documentation.  

The student established a proper follow up plan.  

*Pass = 75% of the overall score Circle: Fail / Pass*

### Comments:

### Overall evaluation

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### Task

4. Demonstrate a musculoskeletal assessment of upper extremity, and head/face, for the purpose of identifying (a) common acquired or congenital risk factors that would predispose the patient to injury and (b) a musculoskeletal injury. This will include identification and recommendations for the correction of acquired or congenital risk factors for injury. At the conclusion of the assessment, the student will diagnose the patient’s condition and determine and apply immediate treatment and/or referral in the management of the condition. Effective lines of communication should be established to elicit and convey information about the patient’s status. While maintaining patient confidentiality, all aspects of the assessment should be documented using standardized record-keeping methods.

### Brief Description:

The CP was performed accurately and in the appropriate order.  

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The student had an effective communication with the patient.  

The student demonstrated proper documentation.  

The student established a proper follow up plan.  

*Pass = 75% of the overall score Circle: Fail / Pass*

### Comments:

### Overall evaluation

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### Task

5. Demonstrate a musculoskeletal assessment of lower extremity, and spine (including the ribs) for the purpose of identifying (a) common acquired or congenital risk factors that would predispose the patient to injury and (b) a musculoskeletal injury. This will include identification and recommendations for the correction of acquired or congenital risk factors for injury. At the conclusion of the assessment, the student will diagnose the patient’s condition and determine and apply immediate treatment and/or referral in the management of the condition. Effective lines of communication should be established to elicit and convey information about the patient’s status. While maintaining patient confidentiality, all aspects of the assessment should be documented using standardized record-keeping methods.
6. Demonstrate a general and specific (e.g., head, torso and abdomen) assessment for the purpose of (a) screening and referral of common medical conditions, (b) treating those conditions as appropriate, and (c) when appropriate, determining a patient’s readiness for physical activity. Effective lines of communication should be established to elicit and convey information about the patient’s status and the treatment program. While maintaining confidentiality, all aspects of the assessment, treatment, and determination for activity should be documented using standardized record-keeping methods.

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*Pass = 75% of the overall score*  
*Circle: Fail / Pass*

Comments:

Overall evaluation

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7. Demonstrate the ability to manage acute injuries and illnesses. This will include surveying the scene, conducting an initial assessment, utilizing universal precautions, activating the emergency action plan, implementing appropriate emergency techniques and procedures, conducting a
secondary assessment and implementing appropriate first aid techniques and procedures for non-life-threatening situations. Effective lines of communication should be established and the results of the assessment, management and treatment should be documented.

<table>
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<tr>
<th>Brief Description:</th>
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<tbody>
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<td>The CP was performed accurately and in the appropriate order.</td>
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**Pass = 75% of the overall score**

**Circle:** Fail / Pass

Comments:

Overall evaluation

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8. Synthesize information obtained in a patient interview and physical examination to determine the indications, contraindications and precautions for the selection, patient set-up, and evidence-based application of therapeutic modalities for acute and chronic injuries. The student will formulate a progressive treatment and rehabilitation plan and appropriately apply the modalities. Effective lines of communication should be established to elicit and convey information about the patient's status and the prescribed modality(s). While maintaining patient confidentiality, all aspects of the treatment plan should be documented using standardized record-keeping methods.

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<td>The student established a proper follow up plan.</td>
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**Pass = 75% of the overall score**

**Circle:** Fail / Pass

Comments:

Overall evaluation
9. Synthesize information obtained in a patient interview and physical examination to determine the indications, contraindications and precautions for the selection, application, and evidence-based design of a therapeutic exercise program for injuries to the upper extremity, lower extremity, trunk, and spine. The student will formulate a progressive rehabilitation plan and appropriately demonstrate and/instruct the exercises and/or techniques to the patient. Effective lines of communication should be established to elicit and convey information about the patient’s status and the prescribed exercise(s). While maintaining patient confidentiality, all aspects of the exercise plan should be documented using standardized record-keeping methods.

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Brief Description: Date(s): 

(e.g. ROM, strength, endurance, speed, power, balance, NM, coordination, agility, cardio, sport skills, work skills)

The CP was performed accurately and in the appropriate order. NP P
The student showed professionalism while performing the task. NP P
The student had an effective communication with the patient. NP P
The student demonstrated proper documentation. NP P
The student established a proper follow up plan. NP P

Pass = 75% of the overall score Circle: Fail / Pass

Comments:

Overall evaluation

Confidence | Skill | Efficiency |
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10. Demonstrate the ability to conduct an intervention and make the appropriate referral of an individual with a suspected substance abuse or other mental health problem. Effective lines of communication should be established to elicit and convey information about the patient’s status. While maintaining patient confidentiality, all aspects of the intervention and referral should be documented using standardized record-keeping methods.

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Brief Description: Date(s): 

The CP was performed accurately and in the appropriate order. NP P
The student showed professionalism while performing the task. NP P
The student had an effective communication with the patient. NP P

Comments:
The student demonstrated proper documentation.  
Pass = 75% of the overall score  
Comments:
Overall evaluation

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11. Demonstrate the ability to select and integrate appropriate motivational techniques into a patient's treatment or rehabilitation program. This includes, but is not limited to, verbal motivation, visualization, imagery, and/or desensitization. Effective lines of communication should be established to elicit and convey information about the techniques. While maintaining patient confidentiality, all aspects of the program should be documented using standardized record-keeping techniques.

Brief Description: Date(s)

The CP was performed accurately and in the appropriate order.  
The student showed professionalism while performing the task.  
The student had an effective communication with the patient.  
The student demonstrated proper documentation.  
The student established a proper follow up plan.  
Pass = 75% of the overall score  
Comments:
Overall evaluation

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12. Demonstrate the ability to counsel a patient in proper nutrition. This may include providing basic nutritional information and/or an exercise and nutrition program for weight gain or weight loss. The student will demonstrate the ability to take measurements and figure calculations for a weight control plan (e.g., measurement of body composition and BMI, calculation of energy expenditure, caloric intake, and BMR). Armed with basic nutritional data, the student will demonstrate the ability to develop and implement a preparticipation meal and an appropriate exercise and nutritional plan for an active individual. The student will develop an active listening relationship to effectively communicate with the patient and, as appropriate, refer the patient to other medical professionals (physician, nutritionist, counselor or psychologist) as needed.

Brief Description: Date(s)

The CP was performed accurately and in the appropriate order.
The student showed professionalism while performing the task.  

The student had an effective communication with the patient. 

The student demonstrated proper documentation. 

The student established a proper follow up plan. 

*Pass = 75% of the overall score* 

**Circle:** Fail / Pass  

Comments:  

Overall evaluation  

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13. Demonstrate the ability to recognize disordered eating and eating disorders, establish a professional helping relationship with the patient, interact through support and education, and encourage vocal discussion and other support through referral to the appropriate medical professionals.

**Brief Description:**

**Date(s):**

| The CP was performed accurately and in the appropriate order. | NP | P |
| The student showed professionalism while performing the task. | NP | P |
| The student had an effective communication with the patient. | NP | P |
| The student demonstrated proper documentation. | NP | P |
| The student established a proper follow up plan. | NP | P |

**Pass = 75% of the overall score** 

**Circle:** Fail / Pass  

Comments:  

Overall evaluation  

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<td>Develop Admin. Plans for</td>
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<td>b. developing policy and procedures</td>
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<td>c. addressing facility hazards</td>
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<td>Professional Development</td>
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<tr>
<td>Collect and disseminate health care information</td>
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</table>
Additional References

Lee University Athletic Training education plan is designed based on reference materials provided by NATA and BOC. These references include:

1. Athletic Training Clinical Proficiencies, 5th edition
   
   NATA Education Council
   
   © 2011 National Athletic Trainers’ Association

2. Certainty in the Professional Practice of Athletic Trainers
   
   Board of Certification
   
   Role of Delineation Study, Fifth edition

These additional references can be reviewed by students at any time. These references are located in the Helen Devos College of Education Building in room EDUC 209D in the program directors office and stored on the computer.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<td>assessment</td>
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<td>C1, C2...</td>
<td>1st cervical vert, 2nd cervical vert...</td>
</tr>
<tr>
<td>CC</td>
<td>chief complaint</td>
</tr>
<tr>
<td>CNS</td>
<td>central nervous system</td>
</tr>
<tr>
<td>CO₂</td>
<td>carbon dioxide</td>
</tr>
<tr>
<td>CP</td>
<td>cerebral palsy</td>
</tr>
<tr>
<td>CPR</td>
<td>cardiopulmonary resuscitation</td>
</tr>
<tr>
<td>CSF</td>
<td>cerebrospinal fluid</td>
</tr>
<tr>
<td>CV</td>
<td>cardiovascular</td>
</tr>
<tr>
<td>CVA</td>
<td>cerebrovascular accident</td>
</tr>
<tr>
<td>cal</td>
<td>calories</td>
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<tr>
<td>cm</td>
<td>centimeter</td>
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<tr>
<td>c/o</td>
<td>complains of</td>
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<tr>
<td>cont.</td>
<td>continue</td>
</tr>
<tr>
<td>D/C</td>
<td>discontinue, discontinued</td>
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<tr>
<td>DFM</td>
<td>deep friction massage</td>
</tr>
<tr>
<td>DIP</td>
<td>distal interphalangeal joint</td>
</tr>
<tr>
<td>DM</td>
<td>diabetes mellitus</td>
</tr>
<tr>
<td>DTR</td>
<td>deep tendon reflex</td>
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<td>Dx</td>
<td>diagnosis</td>
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<tr>
<td>ECG</td>
<td>electrocardiogram</td>
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<td>EKG</td>
<td>electrocardiogram</td>
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<td>EEG</td>
<td>electroencephalogram</td>
</tr>
<tr>
<td>EENT</td>
<td>ears, eyes, nose, and throat</td>
</tr>
<tr>
<td>EMG</td>
<td>electromyogram</td>
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<tr>
<td>ER</td>
<td>external rotation</td>
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<td>ER</td>
<td>emergency room</td>
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<tr>
<td>ext.</td>
<td>extension</td>
</tr>
<tr>
<td>F</td>
<td>fain (muscle strength)</td>
</tr>
<tr>
<td>flex.</td>
<td>flexion</td>
</tr>
<tr>
<td>ft.</td>
<td>foot/feet (unit of measurement)</td>
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<tr>
<td>Fhx, FH</td>
<td>family history</td>
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<tr>
<td>FWB</td>
<td>full weight bearing</td>
</tr>
<tr>
<td>Fx</td>
<td>fracture</td>
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<tr>
<td>F</td>
<td>good (muscle strength)</td>
</tr>
<tr>
<td>GI</td>
<td>gastrointestinal</td>
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<tr>
<td>N</td>
<td>normal (muscle strength)</td>
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<tr>
<td>gm</td>
<td>gram</td>
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<td>GYN</td>
<td>gynecology</td>
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<td>h, hr.</td>
<td>hour</td>
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<td>hs</td>
<td>at bed time</td>
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<tr>
<td>H&amp;P</td>
<td>history and physical</td>
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<td>HA</td>
<td>headache</td>
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<tr>
<td>Hb, Hgb</td>
<td>hemoglobin</td>
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<tr>
<td>HNP</td>
<td>herniated nucleus pulposus</td>
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<td>HP</td>
<td>hot pack</td>
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<tr>
<td>HR</td>
<td>heart rate</td>
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<td>Ht</td>
<td>hematocrit</td>
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<td>Hx</td>
<td>history</td>
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<tr>
<td>IM</td>
<td>intramuscular</td>
</tr>
<tr>
<td>IMP</td>
<td>imp impression</td>
</tr>
</tbody>
</table>
IK  infrared
IR  internal rotation
IV  intravenous

kg  kilogram

lb.  pound (unit of measurement)
L, l.  liter
LE  lower extremity
L1, L2...  1st lumbar, 2nd lumbar vertebra...
LBP  lower back pain
LOC  level of consciousness
LTG  long term goals

m  meter
mg  milligram
min.  minutes
mo.  month
MED  minimal erythemal dose
Meds.  medications
MFT  muscle function test
MP/MCP  metacarpophalangeal
MSCD  multiple sclerosis

neg.  negative
noc  night, at night
N  normal (muscle strength)
NPO  nothing by mouth
NWB  non-weight bearing
od  once daily
oz.  ounce
O:  objective
OB  obstetrics
O.P.  outpatient
P.R.  operating room

pc  after meals
per  by/through
p.o.  by mouth
pos.  positive
poss  possible
post-op  after surgery
pre-op  before surgery
prn  as necessary
pron.  pronation

pt., PT.  patient
P  poor (muscle strength)
P:  plan
Phx, P.H.  past history
PNF  proprioceptive neuromuscular facilitation
PRE  progressive resistive exercise
PROM  passive range of motion
PT  physical therapy
PVD  peripheral vascular disease
PWB  partial weight bearing

q  every
qd  every day
qh  every hour
qid  four times a day
qn  every night
qt.  quart

re:  regarding
resp  respiration
RA  rheumatoid arthritis
RBC  red blood cell count
R/O  rule out
ROM  range of motion
RROM  resistive range of motion
Rx  treatment, prescription
sec.  second (unit of measurement)
sig  directions for use, give as follows
stat.  immediately
sup.  supination
Sx  symptoms
SED  sub-erythemal dose
SI  sacroiliac
SLR  straight leg raises
S/P  status post (after)
STG  short term goals

tab  tablet
temp.  temperature
tid  three times daily
t.o.  telephone order
Tol.  tolerated
T  trace (muscle strength)
TB  tuberculosis
TENS transcutaneous electrical nerve stimulation
TIA transient ischemic attack
TPR temperature, pulse, respiration
TWB total weight bearing
Tx treatment
Tx. traction
UA urine analysis
UE upper extremity
URI upper respiratory infection
US ultrasound
UV ultraviolet
v.o. verbal orders
v.s. vital signs
wk. week
W/cm² watts per square centimeter
WBC white blood count
WNL within normal limits
y/o years old
yr. year
↓ decrease, down
↑ increase, up
c with
p after
a before
+, - positive
negative
~ approximately
@ at
change
< less than
> greater than
= equals
≠ uneven, not equal to
# number (#1 is number one)
# pound (4# is four pounds)
/ per
% percent
&
and
1 primary
2 secondary
: is, was
x, X times
♂ male
♀ female
😊 happy
😊 sad


Stedman’s Medical Dictionary.

Medical Terminology

A-: Prefix meaning without, away from, not.
Ab-: Prefix meaning from, away from, negative, absent.
Abduct: Movement away from the midline of the body.
Abnormal: Contrary to the usual size, location, condition, or system.
Abrasion: A scraping away of the skin.
Abscess: A localized collection of pus in any part of the body.
Acclimatization: Pertains to certain physiological adjustments brought about through continuous exposure to a different climate, e.g., changes in altitude and heat.
Acetylcholine (ACh): A chemical substance involved in several important physiological functions such as transmission of an impulse from one nerve fiber to another across a synapse.
Acid: A chemical compound that gives up hydrogen ions (H+) in solution.
Acromioclavicular joint: A joint in the shoulder girdle between the distal clavicle and the acromion process of the scapula.
Actin: A protein involved in muscle contraction.
Action potential: The electrical activity developed in a muscle or nerve cell during activity or depolarization.
Active transport: The movement of substances or materials against their concentration gradients by the expenditure of metabolic energy.
Acute: Having a rapid onset, severe symptoms, and a short course; not chronic.
Ad-: A prefix meaning toward.
Adduct: Movement toward the midline of the body.

Adipose tissue: Fat tissue.
Aerobic: With oxygen. Refers to one of two metabolic systems that produce ATP for muscle contraction. The other system is anaerobic.
Aerobic power: The maximal amount of oxygen that can be consumed per minute during maximal exercise.
Afferent: Refers to neurons that carry sensory impulses from the periphery to the spinal cord.
Agonist: 1. A muscle in a state of contraction, with reference to its opposing muscle(s). 2. a muscle that effects a movement.
Alactacid oxygen debt: That portion of the recovery oxygen used to resynthesize and restore ATP + PC in muscle following exercise.
Alkaline: Pertaining to a base.
Alkaline reserve: The amount of bicarbonate (base) available in the body for buffering.
Alkalosis: Excessive base (bicarbonate ions) in the extracellular fluids.
All-or-none law: The law stating that when either a muscle or nerve fiber is stimulated above threshold, it will respond maximally.
Alpha motor neurons: A type of efferent nerve cell that enervates extrafusal nerve fibers.
Alveolar-capillary membrane: The thin layer of tissue dividing the alveoli and the pulmonary capillaries where gaseous exchange occurs.
Alveolar ventilation: The portion of inspired air that reaches the alveoli.
Alveolus: Tiny terminal air sacs in the lungs where gaseous exchange with the
blood in the pulmonary capillaries occurs.

**Amino acids**: The basic chemical building blocks of protein.

**Anabolic**: Protein building.

**Anaerobic**: Does not require oxygen. Refers to one of two metabolic systems that produce ATP for muscle contraction. The other system is aerobic.

**Anaerobic power**: The maximal ability of the anaerobic systems (ATP-PC and lactic acid) to produce energy.

**Analgesic**: Something that provides pain relief.

**Anatomical dead space**: That volume of fresh air that remains in the respiratory passages and does not participate in gaseous exchange.

**Androgen**: Any substance that possesses masculinizing properties.

**Anemia**: 1. A condition characterized by below normal RBC concentration; 2. A lack of sufficient RBCs or hemoglobin.

**Anesthesia**: Partial or complete loss of sensation.

**Antagonist**: A muscle that opposes or resists the action of another muscle.

**Anthropometry**: The measurement of the size and proportions of the human body.

**Antibiotic**: A drug used to destroy or inhibit growth of microorganisms.

**Antiseptic**: An agent, similar to an antibiotic, which is used to prevent the growth or arrest the development of microorganisms.

**Apnea (Apneic)**: Cessation of breathing.

**Aqueous**: Pertaining to water.

**Arteriovenous oxygen difference**: The difference between the oxygen content of arterial and venous blood.

**Arthritis**: Inflammation of a joint usually accompanied by pain and sometimes causing changes in the structure of the joint.

**Arthro-**: A prefix pertaining to joints.

**Arthrogram**: A X-ray using a radio-opaque die in the joint.

**Arthroscope**: A device that allows the interior aspects of a joint or structure to be viewed.

**Artery**: A vessel carrying blood away from the heart.

**Aspirate**: To remove fluid from a joint.

**Association**: The act of combining.

**Asystole**: 1. Cardiac standstill. 2. Absence of contractions of the heart.

**Atrophy**: 1. Wasting away of muscle. 2. A decrease in muscle mass.

**Avulsion**: A tearing away of tissue.

**Basal metabolic rate**: The minimal energy expenditure necessary to maintain life.

**Bi-**: A prefix meaning two, double, twice.

**Bilateral**: Both sides of the body.

**Bioenergetics**: The study of energy transformations in living organisms.

**Biopsy**: The removal and examination of tissue from a living body.

**Blood pressure**: A measurement of the pressure within the vascular system that is associated with systole and diastole.

**Brachial plexus**: A group of nerves in the neck and control sensation and movement of the arm.

**Bradycardia**: A decreased or slowed heart rate.

**Buffer**: Any substance in a fluid that lessens the change in hydrogen ions.

**Bursa**: A fluid-filled sac-like structure which acts to reduce friction between joint structures.

**Callous**: A hardened layer of skin.

**Callus**: Healing tissue of a bone fracture.
**Calorie:** A unit of work or energy equal to the amount of work required to raise the temperature of one gram of water one degree centigrade.

**Capsule:** A sleeve-like fibrous covering of a joint.

**Cardiac cycle:** Systole and diastole of the heart.

**Cardiac output:** The amount of blood pumped through the heart per minute.

**Cardiologist:** A physician specializing in the treatment of cardiovascular diseases.

**Cardio respiratory endurance:** The ability of the heart and lungs to take in and transport adequate amounts of oxygen to the working muscles, allowing activities that require large muscle masses (e.g., running, swimming, bicycling) to be performed over a long period of time.

**Central fatigue:** Fatigue that is proximal to the motor end-plates, mainly involving the CNS.

**Central Nervous System (CNS):** The brain and spinal cord.

**Cephalic:** Referring to the head.

**Cholinesterase:** A chemical that deactivates or breaks down acetylcholine.

**Chronic:** Long, drawn-out, of long duration; opposed to acute.

**Concentric contraction:** An increase of intramuscular tension resulting in shortening of the muscle (and movement of the joint affected).

**Concussion:** A partial or complete loss of mental function; may be associated with transient or prolonged loss of consciousness.

**Conduction:** The transfer of heat between objects of different temperatures that are in direct contact with each other.

**Contra-:** A prefix meaning opposite or against.

**Contusion:** A soft tissue injury where the skin is not broken; a bruise.

**Convection:** The transfer of heat from one place to another by the motion of a heated substance.

**Costal:** Pertaining to the ribs.

**Counterirritant:** An agent that is applied locally that produces an inflammation reaction for the purpose of affecting some other part, usually adjacent or underlying the surface treated.

**Cranial:** Pertaining to the head or skull.

**Cross-bridges:** Extensions of myosin.

**Cryogenic:** Pertaining to the production of low temperatures.

**Cryotherapy:** The use of cold in the treatment of injury.

**Debridement:** The process of removing foreign material.

**Dehydration:** The state where the loss of water exceeds intake of water.

**Density:** The mass per unit volume of an object.

**Dermatologist:** A physician who specializes in treatment of conditions of the skin.

**Di-:** A prefix indicating two, double, or twice.

**Diastole:** 1. The period between contractions of the heart. 2. Relaxation of the myocardium.

**Diastolic volume:** The amount of blood that fills the ventricle during diastole.

**Diffusion:** The random movement of molecules due to their kinetic energy.

**Dislocation:** The displacement of any part, especially the joints.

**Dissociation:** The act of separating.

**Dorsum:** The back or posterior aspect of a body or structure.

**Douglas bag:** A rubber-lined, canvas bag used for collection of expired gases.

**Dynamic exercise:** Exercise marked by a change in joint angle.
Dys-: A prefix meaning bad, difficult, or painful.

Dysmenorrhea: Painful menstruation.
Dyspnea: Difficult or labored breathing.

Eccentric contraction: A lengthening of the muscle under tension.
Ecchymosis: Discoloration of skin due to the accumulation of blood in the tissues.
Ectomorph: A body type characterized by fragility and delicacy of body.
Edema: A localized or generalized condition in which the tissues contain an excessive amount of fluid.
Effector: Muscle that responds to efferent (motor) neural commands.
Efferent: Refers to neurons that carry motor impulses to an effector organ in the periphery, that is, skeletal muscle.
Efficiency: The ratio of work output to work input.
Electrical potential: The capacity for producing electrical effects, such as an electric current, between two bodies (e.g., between the inside and outside of a cell).
Electrolytes: 1. A substance that ionizes in solution, such as salt (NaCl), and is capable of conducting an electric current; 2. Ions, primarily sodium, potassium, and chloride, that play an important role in water balance.
Electron: A negatively charged particle.
Embolus: A clot or other plug transported by the blood from another vessel and forced into a smaller one, and thus obstructing circulation.
Endocrine gland: 1. An organ or gland that produces an internal secretion; 2. A ductless gland.
Endomorph: A body type component characterized by roundness and softness of the body.
Endomysium: A connective tissue surrounding a muscle fiber or cell.

Energy: The capacity or ability to perform work.
Epidermis: Outer layer of skin.
Epimysium: A connective tissue surrounding the entire muscle.
Epinephrine: 1. A hormone secreted by the adrenal medulla that stimulates ATP production by its action on fat and muscle cells; 2. The chemical transmitter substance at peripheral sympathetic nerve endings.
Ergogenic aid: 1. Any substance, action, procedure, or influence that improves performance through its effect on the body; 2. Any factor that improves work performance.
Ergometer: 1. An apparatus or device, such as a treadmill or stationary bicycle, used for measuring the physiological effects of exercise; 2. An instrument used to measure the amount of work done.
Erythema: Reddening of the skin.
Evaporation: The loss of heat resulting from changing a liquid to a vapor.
Excess post-exercise oxygen consumption (EPOC): Oxygen consumption greater than resting values recorded during recovery from exercise.
Excitation: A response to a stimulus.
Expiratory reserve volume (ERV): The maximal volume of air expired after end-expiration.
Extra-: Prefix meaning outside of, in addition to, or beyond.
Extracellular: Outside the cell.
Extrafusal fiber: A typical or normal muscle cell or fiber.
Extra systole: An extra heartbeat.

Fasiculus: A group or bundle of skeletal muscle fibers held together by a connective tissue called the perimysium.
Fascia: A sheet or band of fibrous tissue that covers the body under the skin.
Fat: 1. A compound containing glycerol and fatty acids; 2. One of the basic foodstuffs.

Fatigue: A state where a transient decrease of working capacity results from previous physical activity and is characterized by a decrease in mechanical performance. Two types: 1) Central fatigue which is proximal to the motor units and 2) peripheral fatigue which involves the motor neurons, peripheral nerves, motor end-plates, and the muscle fibers.

Fatty acids: One of the basic chemical building blocks of fat in food.

Fiber (muscle): The cylindrical cell, ranging in length from 2 to 50 mm, which constitutes skeletal muscle.

Fiber area: The area taken up by a particular fiber type(s).

Fiber type: Muscle fibers are characterized (typed) according to contractile speed (fast or slow) or metabolic capacities (oxidative or glycolytic).

Fibrillation: 1. Irregularity in force and rhythm of the heart, or a quivering of the muscle fibers, causing inefficient emptying; 2. Spasm of the myocardium.

Flecid: Lacking muscular tone.

Flexibility: 1. A joints range of motion; 2. The extensibility of a muscle.

Flexometer: An instrument used for measuring the range of motion of a joint.

Foot-pound: A work unit; the force that is necessary to move one pound of resistance through one foot of distance.

Fulcrum: The axis of rotation for a lever.

Functional residual capacity: Volume of air in the lungs after a normal expiration.

Gait: Manner of locomotion.

Gastric: Pertaining to the stomach.

Genu: Pertaining to the knee.

Glenohumeral: Pertaining to the shoulder joint.

Glenoid: The socket of the shoulder ball and socket joint.

Glucagon: A hormone secreted by the pancreas that stimulates ATP production by its action on fat cells and the liver.

Glucose: A carbohydrate used as fuel for aerobic and anaerobic metabolism.

Glycogen: Glucose is stored in muscle tissue and in the liver in this form.

Glycolysis: The anaerobic process by which glycolysis is broken down to lactic acid to produce ATP for muscular contraction.

Goniometer: A device used to measure joint angles.

Hallux: The great toe.

Heart rate: The number of times the heart beats each minute.

Hem-, hema-: Prefix referring to blood.

Hematocrit: The percentage of RBC in the blood.

Hematoma: A swelling or mass of blood, usually clotted, confined to any organ, tissue, or space and caused by a break in a blood vessel.

Hematuria: A discharge of blood into the urine.

Hemi-: Prefix meaning half.

Hemoconcentration: Concentration of blood.

Hemodilution: Dilution of blood.

Hemoglobin: 1. A complex iron-protein molecule and is important in the transportation of oxygen and carbon dioxide in the blood; 2. The oxygen-binding pigment of the blood.

Hemolysis: The rupture of a cell, such as a RBC.

Hemorrhage: An abnormal discharge of blood.

Hernia: The protrusion of projection of an organ or structure or part of an organ
through the wall of the cavity which normally contains it.

**Homeostasis:**  
[homeo=like+stasis=standing] The state of equilibrium (balance between opposing pressures) in the body.

**Hormone:** A chemical substance secreted by an endocrine (ductless) gland, which is absorbed into the blood and influences the growth, development, and function of some other part of the body.

**Hydro-**: Pertaining to water.

**Hypercapnia:** Excess carbon dioxide content of the blood.

**Hyperoxia:** Excess oxygen content.

**Hyperplasia:** A change in the tissue cross-section caused by the growth of new fibers; in increase in the number of cells in a tissue or organ.

**Hyperpnea:** Increase in rate and depth of breathing as with exercise.

**Hypertension:** High blood pressure.

**Hypertonic:** Increase in muscle tone resulting in muscular tension.

**Hypertrophy:** 1. A general increase in bulk; 2. The increased cross-sectional dimension of the muscle fiber. Use of the term denotes greater bulk through increase in size, not number.

**Hyperventilation:** More air than is normal in the lungs. Can lead to respiratory alkalosis due to washing carbon dioxide from the blood.

**Hypervolemia:** An increase in the volume of blood.

**Hypocapnia:** Low carbon dioxide content of the blood.

**Hypotension:** Low blood pressure.

**Hypotonic:** Pertaining to a solution having a lesser tension or osmotic pressure than one with which it is being compared.

**Hypoventilation:** Less air in the lungs than is normal. Can lead to respiratory acidosis due to retention of carbon dioxide in the blood.

**Hypovolemic:** A decreased volume of blood.

**Hypoxia:** Low oxygen content.

**Inert:** Having no action.

**Infra-**: Prefix meaning below, under, beneath, inferior to.

**Inspiratory capacity (IC):** The volume of air in the lungs after a normal inspiration.

**Inspiratory reserve volume:** That volume of air that the lungs can hold after a normal tidal inspiration.

**Insulin:** A hormone secreted by the pancreas that facilitates the uptake of blood glucose and amino acid by the cells. This hormone also inhibits the effects of epinephrine and glucagon.

**Inter-**: Prefix meaning in the midst, between.

**Interstitial:** Pertaining to the area or space between the cells.

**Interval training:** An advanced form of training in which periods of high and low intensities are alternated. Because the high intensities are brief they may be performed at intensities much higher than otherwise possible. Also since they are alternated with periods of rest some degree of recuperation may take place.

**Intrafusal fiber:** A muscle fiber (cell) that houses the muscle spindle.

**Ion:** An electrically charged particle.

**Isocapnia:** Normal carbon dioxide content.

**Isokinetic exercise:** Exercise in which the angular velocity of muscle contraction is held constant.

**Isometric:** A muscle contraction that results in no movement of the joint affected.

**Isometric exercise:** 1. A resistive exercise protocol that involves no
movement; 2. A contraction in which tension is developed, but there is no change in the length of a muscle.

**Isotonic exercise**: A resistive exercise protocol characterized by a constant intramuscular tension.

**Itis-**: Prefix meaning inflammation of.

**Kilocalorie (kcal)**: The unit of measure used to describe both energy intake and energy expenditure.

**Kinesthesis**: Awareness of body position.

**Kyphosis**: Exaggerated curvature of the upper back; hunchback.

**Lactacid oxygen debt**: That portion of the recovery oxygen used to remove accumulated lactic acid from the blood following exercise.

**Laceration**: A wound or irregular tear of the flesh.

**Lactic acid**: An end product of anaerobic glycolysis.

**Lateral**: Pertains to the side; to the side of the midline of the body or structure.

**Lean body weight**: The weight of the body minus the weight of body fat.

**Lordosis**: Abnormal anterior curvature of the spine.

**Mal-**: Prefix meaning ill, bad, poor.

**Malacia**: Abnormal softening of the tissues.

**Malingering**: One who pretends to be ill or injured or has a slow recovery for secondary gain.

**Maximal oxygen consumption (max Vo²)**: The maximal rate at which oxygen can be consumed per minute; the power or capacity of the aerobic energy system.

**Medial**: Towards the midline of the body or structure.

**Median**: Middle, central.

**Mega-**: Prefix meaning great or large.

**Membrane**: A thin layer of tissue that covers a surface or divides a space or organ.

**Menarche**: The onset of menstruation.

**Menses**: The monthly flow of blood from the genital tract of women.

**Menstruation**: The process or an instance of discharging the menses.

**Mesomorph**: A body type component characterized by a square body with hard, rugged, and prominent musculature.

**Metabolism**: The chemical changes within the body that provide energy and maintain life.

**Metabolite**: Any substance produced by a metabolic reaction.

**Mitochondria**: Sub-cellular structures found in all aerobic cells, and where metabolism takes place; also called the "powerhouse of the cell".

**Moment (moment arm)**: The perpendicular distance from the line of action of the force to the point of rotation.

**Motor end-plate**: The anatomical site at which the neuron's axon terminates in muscle tissue.

**Motor unit**: A single motor neuron (efferent) and all the muscle fibers that it enervates.

**My- or Myo-**: Prefix pertaining to muscle.

**Myofibril**: An individual muscle fiber; a cell in itself.

**Muscle spindle**: A proprioceptor located within an interfusal muscle fiber.

**Muscular endurance**: The ability of a muscle or muscle group to perform repeated contractions.

**Myoglobin**: An oxygen-binding pigment of the muscle, similar to hemoglobin and gives red muscle fiber its color; stores and aids in the diffusion of oxygen.
**Myosin**: A protein involved in muscular contraction.

**Necrosis**: Death of areas of tissues or bone surrounded by healthy tissues or bone.

**Negative energy balance**: A condition in which less energy (food) is taken in than is given off; body weight decreases as a result.

**Net oxygen cost**: The amount of oxygen, above resting values, required when performing a given amount of work.

**Neuro-**: Prefix relating to a nerve, nervous tissue, or the nervous system.

**Neuron**: The basic anatomical unit of the nervous system. It consists of a cell body, dendrites, and an axon.

**Norepinephrine**: The chemical transmitter substance at peripheral sympathetic nerve endings.

**Normoxia**: Normal oxygen content.

**-ology**: Suffix pertaining to the study of, knowledge of, or science of.

**-oma**: Suffix denoting a tumor or swelling.

**Ophthalmologist**: A physician who specializes in the treatment of eye disorders.

**Ortho-**: Prefix pertaining to straight, proper, normal, in proper order.

**Orthopaedics or Orthopedics**: The branch of medical science that deals with prevention and correction of disorders of locomotor structures of the body, especially the skeleton, joints, muscles, and fascia.

**Orthotic**: A mechanical appliance for orthopaedic use.

**Osmosis**: The diffusion through a semi-permeable membrane of a solvent such as water from a lower to a more concentrated solution.

**Osmosis pressure**: The force per unit area needed to stop osmosis.

**Osteo-**: Prefix pertaining to bone.

**Otorrhea**: Discharge of fluid from the ear. May indicate a head injury.

**Overload principle**: Progressively increasing the intensity of the workouts over the course of the training program as fitness capacity improves.

**Oxidation**: The removal of electrons.

**Oxygen consumption**: The amount of oxygen the body consumes each minute.

**Oxygen debt**: A term that has been used to explain the excess post-exercise oxygen consumption.

**Oxyhemoglobin (HbO²)**: Hemoglobin chemically combined with oxygen.

**Palpate**: To examine by touch; to feel.

**Paralysis**: Temporary suspension of function or permanent loss of function.

**Parasympathetic**: Pertaining to the craniosacral portion of the autonomic nervous system.

**Paravertebral**: Alongside or near the vertebral column.

**Paresis**: Partial or complete paralysis.

**Paresthesia**: Abnormal sensation; heightened sensitivity.

**Partial pressure**: The pressure exerted by a gas in relation to its percentage or concentration in a gas volume.

**Pathology**: Study of the nature and cause of disease which involve changes in structure and function; also, a condition produced by disease.

**Perfusion**: An adequate supply of blood to tissues and organs.

**Perimysium**: A connective tissue surrounding a fasciculus.

**Periosteum**: Membrane covering bone.

**Peripheral fatigue**: Also: Local fatigue: Fatigue involving the motor neurons, peripheral nerves, motor end-plates, and muscle fibers.
**Peritoneum**: The thin membrane that secretes serous fluid and lines the walls of the abdominal cavity and encloses the viscera.

**Peritonitis**: Inflammation of the peritoneum.

**Pes**: Generally refers to the foot.

**pH**: The power of the hydrogen ion.

**Phosphagen**: A group of compounds; collectively refers to ATP and PC.

**Phosphocreatine (PC)**: A chemical compound stored in muscle, which when broken down aids in manufacturing ATP.

**Placebo**: An inert substance having the identical physical characteristics of a real drug.

**Plasmolysis**: The shrinking of a cell, such as the RBC.

**Pleura** (singular) or **Pleurae** (plural): A thin membrane that secretes serous fluid and lines the thoracic wall (parietal pleura), the diaphragm (diaphragmatic pleura), and the lungs (visceral pleura).

**Pneumothorax**: The entrance of air into the pleural cavity.

**Podiatrist**: One who treats foot disorders.

**Polycythemia**: An increased production of RBC.

**Ponderal index**: Body height divided by the cube root of body weight.

**Positive energy balance**: A condition in which more energy (food) is consumed than is expended and results in increased body weight.

**Postsynaptic neuron**: A nerve cell located distal to a synapse.

**Power**: Work done per unit of time (i.e., if one pound was raised one foot in one second, power is expressed as 1 foot-pound/second.

**Pre-**: Prefix meaning before or in front of.

**Pressure**: Force per unit of area.

**Proprioception**: The peripheral control process by which feedback is provided concerning position, length, and tension in muscles, tendons, or joints.

**Proprioceptor**: Sensory organs found in muscles, joints, and tendons which provides information concerning movements and position of the body (kinesthesia).

**Protein**: A compound containing amino acids; one of the basic foodstuffs.

**Psychomotor**: An instrument used for measuring the relative humidity.

**Pulmonary circuit**: The flow of blood from the heart to the pulmonary capillaries and the venous blood from the pulmonary capillaries back to the heart.

**Pyruvic acid**: The end-product of aerobic glycolysis; the precursor of lactic acid.

**Q**: Resting cardiac output. Does not change with training. \( Q = SV \times HR \)

**Radiologist**: A physician who specializes in diagnosis and treatment using imaging systems.

**Receptor**: A sense organ that receives stimuli.

**Reflex**: An automatic response induced by stimulation of a receptor.

**Reflex arc**: An anatomical unit that conducts impulses via an afferent neuron through the spinal cord and directly into an efferent neuron, producing an involuntary response in an effector organ.

**Relative humidity**: Ratio of water vapor in the atmosphere to the amount of water vapor required to saturate the atmosphere at the same temperature.

**Relief interval**: In an interval-training program, the time between work intervals as well as the period of time between sets.
**Repetition maximum (RM):** The maximal load that a muscle group can lift over a given number of repetitions before fatiguing (i.e., a 10RM load is the maximal load that can be lifted 10 times).

**Residual volume:** The volume of aid remaining in the lungs after maximal expiration.

**Respiration:** The breakdown of food, in the presence of oxygen, to carbon dioxide and water with the liberation of chemical energy.

**Respiratory exchange ratio (R, RQ):** The ratio of the amount of carbon dioxide produced to the amount of oxygen consumed ($V_{CO^2}/V_{O^2}$).

**Resting membrane potential:** The electrical difference between the inside and outside of the cell (i.e., across the cell membrane) at rest.

**Retrograde amnesia:** Loss of memory of events that precede an injury.

**Rheumatism:** A general term for acute and chronic conditions characterized by soreness and stiffness, and pain in joints and related structures.

**Rhinorrhea:** Discharge of spinal fluid from the nose indicating a severe head injury.

**Saline:** A 0.9% salt solution that is isotonic to the blood.

**Sarcolemma:** The muscle cell membrane.

**Sarcomere:** The basic contractile unit in the muscle fiber; the distance between two Z-lines; the smallest contractile unit of skeletal muscle.

**Sarcoplasm:** Muscle protoplasm.

**Sarcoplasmic reticulum:** A network of tubules and vesicles surrounding the myofibril.

**Scoliosis:** An abnormal lateral curvature of the spine.

**Sensory neuron:** A nerve cell that conveys impulses from a receptor cell to the central nervous system.

**Serous fluid:** A watery fluid secreted by the pleurae.

**Set:** In an interval training program, a group of work and relief intervals.

**Somatic:** Pertaining to the body.

**Somatotype:** The body type or physical classification of the human body.

**Specific dynamic action:** An increase in metabolic rate associated with the digestion of food.

**Specific gravity:** The ratio of the density of an object to the density of water.

**Specificity of training:** The principle behind the design of a training program for a specific activity or skill and the primary energy system(s) involved during performance.

**Spirometer:** A steel container used to collect, store, and measure either inspired or expired gas volumes.

**Sprain:** A joint injury involving ligaments.

**Strain:** Injury to a muscle or a tendon due to excessive stretch.

**Steady state:** Pertaining to the time period during which a physiological function (such as $V_{O^2}$) remains at a constant (or steady) value.

**Steroid:** A derivative of the male sex hormone, testosterone, which has masculinizing properties.

**Strength:** The ability to perform work.

**Stroke volume:** The amount of blood pumped out of the heart during each contraction.

**Sub-:** Prefix denoting under, beneath, in small quantity.

**Sudomotor:** Pertaining to activation of the sweat glands.

**Superior:** Higher than or better than.

**Supra-:** Prefix meaning above.
Sympathetic: Pertaining to the thoracolumbar portion of the autonomic nervous system.

Synapse: An anatomical unit that serves as the connective link between neurons.

Synaptic cleft: The gap between presynaptic and postsynaptic neurons.

Synergist: Muscles or muscle groups that work together to effect a movement.

Synovial membrane: Membrane lining the capsule of a joint.

Synovial fluid: Fluid lubricating a joint.

Synovitis: Inflammation of a synovial membrane.

Systemic: 1. Any complex of structures anatomically related (e.g. the vascular system) or functionally related (e.g., the digestive system). Relating to a system.

Systemic circuit: The flow of arterial blood from the heart to the body tissues (such as the muscles) and of the venous blood from the tissues back to the heart.

Systole: A contraction of the myocardium; the emptying phase of the cardiac cycle.

Tachycardia: An increased or rapid heart rate.

Testosterone: The male sex hormone secreted by the testicles and possesses masculinizing properties.

Thermodynamics: The science of the transformation of heat and energy.

Tidal volume (TV): The volume of air of a normal inspiration or expiration.

Tissue-capillary membrane: The thin layer of tissue dividing the capillaries and an organ (such as skeletal muscle) and is the site at which gaseous exchange occurs.

Tonus: Resiliency and resistance to stretch in a relaxed, resting muscle.

Total lung capacity (TLC): Volume of air in the lungs at the end of maximal inspiration.

Transverse: Lying across; crosswise.

Trauma: A physical injury or wound caused by external force or violence.

Trophic: Combining form denoting nutrition.

Tropomyosin: A protein involved in muscular contraction.

Troponin: A protein involved in muscular contraction.

Valsalva maneuver: Attempting expiration with the glottis closed.

Variable resistance exercise: Resistance within a single repetition varies.

Vaso-: Prefix referring to blood vessels.

Vasoconstriction: A decrease in the diameter of a blood vessel (usually an arteriole) resulting in a reduction of blood flow to the area supplied by the vessel.

Vasodilatation: An increase in the diameter of a blood vessel (usually an arteriole) resulting in an increased flow of blood to the area supplied by the vessel.

Vasomotor: Pertaining to vasoconstriction and vasodilation.

Venous constriction: A decrease in the diameter of a vein.

Ventilatory efficiency: The amount of ventilation required per liter of oxygen consumed (Ve/Vo^2).

Viscera (plural); Viscus (singular): The internal organs of the body.

Visceral: Pertaining to the viscera.

Vital capacity (VC): Maximal volume of air forcefully expired after maximal inspiration.

Vitamin: An inorganic material in the presence of which important chemical (metabolic) reactions occur.
**WBGT Index**: An index calculated from dry bulb, wet bulb, and black bulb temperatures and indicates severity of environmental heat conditions.

**Wet bulb thermometer**: An ordinary thermometer with a wetted wick wrapped around the bulb; the wet bulbs temperature is related to the amount of moisture in the air; when the wet bulb and dry bulb temperatures are equal the air is completely saturated with water and the relative humidity is equal to 100%.

**Work**: *Physics definition*: The application of force through a distance (application of 1 pound through 1 foot equals 1 foot-pound of work); *Our definition*: Exercise.

**Work interval**: That portion of an interval-training program consisting of the work effort.

**Work-relief**: In an interval training program, a type of relief interval involving light or mild exercise such as rapid walking or jogging.

**Work:relief ratio**: In an interval training program, a ratio relating the duration of the work interval to the duration of the relief interval. As an example, a work:relief ratio of 1:3 means that the work interval is one unit of time and the rest interval is 3 units of time; a ratio of 1:1 means the work and relief intervals are equal.

*Physiology of Exercise*.  H DeVries.
Appendix B
OSHA Guidelines

Effective Hand Washing

Effective hand washing requires the use of soap and water, combined with vigorous washing. After you have lathered your hands vigorously for 10 seconds, you should rinse using a steady stream of running water.

Complete the procedure by using paper towels to thoroughly dry your hands and turn off the faucet.

Personal Protective Equipment

Personal protective barriers will be used to reduce the risk of exposure by keeping potentially infected blood and other body fluids from coming in contact with your skin or mucous membranes.

Examples of personal protective equipment include: gloves, which can reduce contamination of the hands; gowns and aprons, which can prevent contamination of clothing; and masks and protective eyewear, which help reduce the contamination of mucous membranes of the mouth, nose, and eyes. Personal protective equipment appropriate to the needs of this facility will be made available to you. If you have documented allergic reaction to such items as rubber, latex, or plastic, alternatives will be provided.

Gloves

Gloves must be worn in these situations:

- When it can be reasonably anticipated that you may have hand contact with blood, other potentially infectious materials, mucous membranes, and non-intact skin.
- When handling or touching contaminated items or surfaces.

Disposable (single use) gloves, such as surgical or examination gloves must be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised.

Disposable (single use) gloves must not be washed or decontaminated for reuse.

Regulated Waste

Regulated waste includes those contaminated items, which will release blood or potentially infectious materials when compacted (i.e., disposable gloves which are caked with dried blood; and contaminated sharps that can penetrate the skin such as needles, scalpels, or broken glass). Regulated waste includes but is not limited to the following items: joint aspirate, grossly bloody dressings, blood, vomitus, and contaminated sharps/needles.
There are standard procedures for disposing of regulated waste. These procedures include placing the waste in leak proof containers. These containers are labeled with the biohazard symbol. The procedures are designed to protect the people who handle this regulated waste.

When removing waste from waste containers personnel must wear gloves and double bag the infectious waste with another red biohazard labeled bag and secure bag with another biohazard label.

The designated place for waste pick up is in the university health clinic.

**Sharps**

Needle stick injuries are the most serious risk to healthcare workers.

Contaminated needles and other contaminated sharps must immediately be discarded in puncture-resistant, closable, leak proof, and properly labeled or color-coded containers. Do not bend, recap, or break used needles. If you must recap or remove a needle/sharp, a mechanical device or one-handed technique must be used.

Sharps disposal containers will be located as close as possible to the area where they are used. They must remain upright at all times and must be replaced when ¾ full.

Never reach into one of these containers for ANY reason. When using a sharps container, do not open, empty, or clean it in any way that might result in an accidental needle stick.

When disposing of the sharps container, close it securely and place the container in the designated infectious waste disposal container.

**Disposal of Non-Sharp Wastes**

A puncture resistant is not necessary for disposing of blood, body tissue and other contaminated items which do not contain sharps. However, the container must be closable, leak proof, and properly labeled.

**Cleaning and Disinfecting**

Worksites must be maintained in a clean and sanitary condition. When cleaning a blood or body fluid spill you must put on disposable gloves, spray the contaminated area with an appropriate disinfectant or 10% bleach solution. Then blot or pick up the liquid spill with paper towel and put this and contaminated gloves in a regulated waste container. The area is cleaned a second time with the same procedure while wearing clean gloves.

EATING, DRINKING, APPLYING COSMETICS AND/OR LIPP BALM, AND HANDLING CONTACT LENSES IS NOT PERMITTED IN WORK AREAS WHERE EXPOSURE MAY OCCUR.
Tables must be cleaned periodically with at least a 10% bleach solution or other commercially accepted sprays that kill infectious germs.

Floors will be treated as needed for any regulated waste with commercial disinfectants in which the personnel must wear protective gloves and must dispose of all contaminated waste in the biohazard container.

Place any contaminated laundry in a closable, leak proof container until proper decontamination is possible. Try to handle towels as little as possible. Partial saturation may be washed in a 10% bleach solution prior to reuse.

**Summary**

An awareness of and compliance with the recommendations outlined in this material is essential. This will help to assure a safe work environment, thereby reducing the risk of occupational exposure to blood borne pathogens.

Because of the potential for the infection from often-unsuspected sources, you must always be alert. Taking a few minutes and utilizing precautions could have monumental long term repercussions; therefore following a few steps will help everyone maintain a good personal health and safety.

Appendix C
NATA Code of Ethics

PREAMBLE
The National Athletic Trainers’ Association Code of Ethics states the principles of ethical behavior that should be followed in the practice of athletic training. It is intended to establish and maintain high standards and professionalism for the athletic training profession.

The principles do not cover every situation encountered by the practicing athletic trainer, but are representative of the spirit with which athletic trainers should make decisions. The principles are written generally; the circumstances of a situation will determine the interpretation and application of a given principle and of the Code as a whole. When a conflict exists between the Code and the law, the law prevails.

PRINCIPLE 1:
Members shall respect the rights, welfare and dignity of all.
1.1 Members shall not discriminate against any legally protected class.
1.2 Members shall be committed to providing competent care.
1.3 Members shall preserve the confidentiality of privileged information and shall not release such information to a third party not involved in the patient’s care without a release unless required by law.

PRINCIPLE 2:
Members shall comply with the laws and regulations governing the practice of athletic training.
2.1 Members shall comply with applicable local, state, and federal laws and institutional guidelines.
2.2 Members shall be familiar with and abide by all National Athletic Trainers’ Association standards, rules and regulations.
2.3 Members shall report illegal or unethical practices related to athletic training to the appropriate person or authority.
2.4 Members shall avoid substance abuse and, when necessary, seek rehabilitation for chemical dependency.

PRINCIPLE 3:
Members shall maintain and promote high standards in their provision of services.
3.1 Members shall not misrepresent, either directly or indirectly, their skills, training, professional credentials, identity or services.
3.2 Members shall provide only those services for which they are qualified through education or experience and which are allowed by their practice acts and other pertinent regulation.
3.3 Members shall provide services, make referrals, and seek compensation only for those services that are necessary.
3.4 Members shall recognize the need for continuing education and participate in educational activities that enhance their skills and knowledge.
3.5 Members shall educate those whom they supervise in the practice of athletic training about the Code of Ethics and stress the importance of adherence.
3.6 Members who are researchers or educators should maintain and promote ethical conduct in research and educational activities.
PRINCIPLE 4:
Members shall not engage in conduct that could be construed as a conflict of interest or that reflects negatively on the profession.

4.1 Members should conduct themselves personally and professionally in a manner that does not compromise their professional responsibilities or the practice of athletic training.

4.2 National Athletic Trainers’ Association current or past volunteer leaders shall not use the NATA logo in the endorsement of products or services or exploit their affiliation with the NATA in a manner that reflects badly upon the profession.

4.3 Members shall not place financial gain above the patient’s welfare and shall not participate in any arrangement that exploits the patient.

4.4 Members shall not, through direct or indirect means, use information obtained in the course of the practice of athletic training to try to influence the score or outcome of an athletic event, or attempt to induce financial gain through gambling.
Appendix D
Academic Administrative Structure:
Faculty
Academic Administrative Structure:
Preceptors

- Kelly Lumpkin, ATC
  Faculty & Program Director

- DeWayne Knight, MD, ATC
  Faculty, Medical Director, & Preceptor

- Taz Kicklighter, ATC
  Faculty & Clinical Coordinator,

- Jeff Mullins, ATC
  Preceptor

- Alex Grell, ATC
  Preceptor

- Fred “Jersey” DeMarco
  ATC, Preceptor

- Bob Nevil, PT, ATC
  Preceptor

- Randy Wilkes, ATC
  Preceptor

- Tiffany Wilkes, ATC
  Preceptor

- Dr. Richardson, MD
  Preceptor

- Kim Tucker, ATC, PTA
  Preceptor

- Dr. Grebner, DO
  Preceptor

- Mickey Moore, RN
  Preceptor

- Jessica Covert, ATC
  Preceptor

- Rebecca Parker ATC
  Preceptor

- Mel Igot, PT
  Preceptor

- Kathleen Kerecman, ATC
  Faculty & Preceptor
Academic Administrative Structure:
Guest Lecturers

Kelly Lumpkin, ATC
Faculty & Program Director

DeWayne Knight, MD, ATC
Faculty, Medical Director, Preceptor

Taz Kicklighter, ATC
Coordinator of Clinical Instruction

Larry Spense, PM, EMT
Don Hakes, PA

Dr. Richardson, MD
Bob Nevil, PT, ATC

Kim Tucker, ATC
Mickey Moore, RN

Mark Lee, DC
Tony Edwards, NP, ORT
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## Facilities

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<td>Advanced Physical Therapy</td>
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<td>790-7990</td>
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<td>Athletic Training Room</td>
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<td>Benchmark Physical Therapy</td>
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<td>559-0103</td>
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<td>Campus Security</td>
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<td>Center for Sports Medicine and Orthopedics</td>
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<td>Grace Baptist Academy</td>
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<tr>
<td>Student Health Center</td>
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Appendix E

Standards for the Accreditation of Professional Athletic Training Programs
© Commission on Accreditation of Athletic Training Education
July 1, 2012
Standards for the Accreditation of Professional Athletic Training Programs

The purpose of the Commission on Accreditation of Athletic Training Education (CAATE) is to develop, maintain, and promote appropriate minimum education standards for quality for athletic training programs. CAATE is sponsored by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Orthopaedic Society for Sports Medicine, and the National Athletic Trainers’ Association (NATA).

The Standards for the Accreditation of Professional Athletic Training Programs (Standards) are used to prepare entry-level athletic trainers. Each institution is responsible for demonstrating compliance with these Standards to obtain and maintain recognition as a CAATE-accredited professional athletic training program. A list of accredited programs is published and available to the public.

These Standards are to be used for the development, evaluation, analysis, and maintenance of athletic training programs. Via comprehensive and annual review processes, CAATE is responsible for the evaluation of a program’s compliance with the Standards. The Standards provide minimum academic requirements; institutions are encouraged to develop sound innovative educational approaches that substantially exceed these Standards. The Standards also contain a glossary of terms used throughout the process; the definition provided in the glossary must be applied as stated.

Description of the Professional
Athletic Trainers are healthcare professionals who collaborate with physicians to optimize activity and participation of patients and clients. Athletic training encompasses the prevention, diagnosis and intervention of emergency, acute and chronic medical conditions involving impairment, functional limitations and disabilities. Athletic Training is recognized by the American Medical Association (AMA) as a healthcare profession.

The athletic trainer’s professional preparation is based on the development of the current knowledge, skills, and abilities, as determined by the Commission (currently the 5th Edition of the NATA Athletic Training Education Competencies). The knowledge and skills identified in the Competencies consist of 8 Content Areas:
--- Evidence-Based Practice
--- Prevention and Health Promotion
--- Clinical Examination and Diagnosis
--- Acute Care of Injury and Illness
--- Therapeutic Interventions
--- Psychosocial Strategies and Referral
--- Healthcare Administration
--- Professional Development and Responsibility
2012 CAATE Standards

Sponsorship

1. The sponsoring institution must be accredited by an agency recognized by the United States Department of Education or by the Council for Higher Education Accreditation and must be legally authorized to provide a program of postsecondary education. For programs outside of the United States, the institution must be accredited by a recognized post-secondary accrediting agency.

2. CAATE accredited professional athletic training programs must lead to a degree in Athletic Training. The program must be identified as an academic athletic training degree in institutional academic publications. The degree must appear on the official transcript similar to normal designations for other degrees at the institution.

3. All sites where students are involved in patient care or observation-only experience (excluding the Program’s sponsoring institution) must have an affiliation agreement or memorandum(s) of understanding that is endorsed by the appropriate administrative authority (i.e. those bearing signature authority) at both the sponsoring institution and site. In the case where the administrative oversight of the preceptor differs from the affiliate site, formal agreements must be obtained from all parties.

Outcomes

4. Develop a Plan: There must be a comprehensive assessment plan to evaluate all aspects of the educational program. Assessments used for this purpose must include those defined in Standards 6 and 7. Additional assessments may include, but are not limited to, clinical site evaluations, preceptor evaluations, completed clinical proficiency evaluations, academic course performance, retention and graduation rates, graduating student exit evaluations, and alumni placement rates one year post graduation.

5. Develop a Plan: The plan must be ongoing and document regular assessment of the educational program.

6. Assessment Measures: The program’s assessment measures must include those stated in this Standard (6) and Standard 7 in addition to any unique metrics that reflect the specific program, department, or college. The specific volume and nature of this information is influenced by the individual character of the institution and should be in keeping with other similar academic programs within the institution. The assessment tools must relate the program’s stated educational mission, goals and objectives to the quality of instruction, student learning, and overall program effectiveness.

7. Assessment Measures: The program’s BOC examination aggregate data for the most recent three test cycle years must be provided and include the following metrics: Number of students graduating from the program who took the examination, number and percentage of students who passed the examination on the first attempt, and overall number and percentage of students who passed the examination regardless of the number of attempts.

8. Assessment Measures: Programs must post the data from Standard 7 on the program’s home page or a direct link to the data must be on the program’s home webpage.

9. Collect the Data: Programs must obtain data to determine program outcomes as indicated in Standards 6-8 (above).

10. Data Analysis: Programs must analyze the outcomes data to determine the extent to which the program is meeting its stated mission, goals, and objectives.
11. Data Analysis: Programs must meet or exceed a three year aggregate of 70 percent first-time pass rate on the BOC examination.

12. Action Plan: The results of the data analysis are used to develop a plan for continual program improvement. This plan must:
   a. Develop targeted goals and action plans if the program and student learning outcomes are not met; and
   b. State the specific timelines for reaching those outcomes; and
   c. Identify the person(s) responsible for those action steps; and
   d. Provide evidence of periodic updating of action steps as they are met or circumstances change.

13. Action Plan: Programs that have a three-year aggregate BOC first-time pass rate below 70% must provide an analysis of the deficiencies and develop an action plan for correction.

**Personnel**

14. The Program Director must be a full-time employee of the sponsoring institution.

15. The Program Director must have full faculty status, rights, responsibilities, privileges, and full college voting rights as defined by institution policy and that are consistent with similar positions at the institution necessary to provide appropriate program representation in institutional decisions.

16. The Program Director must have programmatic administrative and supervisory responsibility assignment that is consistent with other similar assignments within the degree-granting unit at the institution.

17. The Program Director must have administrative release time. The Program Director’s release time must be equivalent to similar health care programs in the institution. If no such similar program exists at the institution, then benchmark with peer institutions.

18. The Program Director’s Responsibilities must include input to and assurance of the following program features:
   a. Ongoing compliance with the Standards;
   b. Planning, development, implementation, delivery, documentation, and assessment of all components of the curriculum;
   c. Clinical education;
   d. Programmatic budget.

19. Program Director Qualifications: The Program Director must be certified, and be in good standing with the Board of Certification (BOC).

20. Program Director Qualifications: The Program Director must possess a current state athletic training credential and be in good standing with the state regulatory agency (where applicable).

21. Program Director Qualifications: The Program Director must be qualified commensurate with other administrative positions within similar health care programs in the institution. If no such similar program exists at the institution, then benchmark with peer institutions.

22. Clinical Education Coordinator: A faculty member (the Program Director or other duly appointed faculty) must be identified as the Clinical Education Coordinator.

23. Clinical Education Coordinator: The Clinical Education Coordinator must be allowed release/reassigned workload to meet the institutional responsibilities for Clinical Education.

24. Responsibilities of the Clinical Education Coordinator: The Clinical Education Coordinator must assure the following:
   a. Student clinical progression;
   b. Clinical site evaluation;
   c. Student evaluation;
   d. Preceptor training;
25. Preceptor evaluation.

26. Athletic Training Faculty Qualifications: All faculty assigned and responsible for the instruction of athletic training knowledge, skills, and abilities in required coursework must be qualified through professional preparation and experienced in their respective academic areas as determined by the institution.

27. Athletic Training Faculty Qualifications: All faculty assigned and responsible for the instruction of athletic training knowledge, skills, and abilities in required coursework must be recognized by the institution as having instructional responsibilities.

28. Athletic Training Faculty Qualifications: All faculty assigned and responsible for the instruction of athletic training knowledge, skills, and abilities in required coursework must incorporate the most current athletic training knowledge, skills, and abilities as they pertain to their respective teaching areas.

29. Athletic Training Faculty Qualifications: All faculty assigned and responsible for the instruction of athletic training knowledge, skills, and abilities in required coursework must possess a current state credential and be in good standing with the state regulatory agency (where and when applicable) when teaching hands-on athletic training patient care techniques with an actual patient population.

30. Athletic Training Faculty Qualifications: All athletic trainers who are identified as the primary instructor for athletic training courses (as identified by the matrix) must be certified and in good standing with the BOC and, where applicable, be credentialed by the state.

31. Athletic Training Faculty Number: In addition to the Program Director, there must be a minimum one full-time (1.0 FTE) faculty member as defined in the glossary, dedicated (100% of 1 FTE) to the athletic training program. (revised March 1, 2013, all programs must be in compliance by July 1, 2015)

32. Athletic Training Faculty: Based on the program’s student enrollment, the number of athletic training faculty must be sufficient to advise and mentor students.

33. Athletic Training Faculty: Based on the program’s student enrollment, the number of athletic training faculty must be sufficient to meet program outcomes.

34. Athletic Training Faculty: Based on the program’s student enrollment, the number of athletic training faculty must be sufficient to allow the institution to offer athletic training courses on a regular, planned basis.

35. Medical Director: The Medical Director must be an MD/DO who is licensed to practice in the state sponsoring the program.

36. Medical Director: The Medical Director must in coordination with the Program Director, serve as a resource and medical content expert for the program.

37. Preceptor Responsibilities: A preceptor must function to:
   a. Supervise students during clinical education;
   b. Provide instruction and assessment of the current knowledge, skills, and clinical abilities designated by the Commission;
   c. Provide instruction and opportunities for the student to develop clinical integration proficiencies, communication skills and clinical decisionmaking during actual patient/client care;
   d. Provide assessment of athletic training students’ clinical integration proficiencies, communication skills and clinical decision-making during actual patient/client care;
   e. Facilitate the clinical integration of skills, knowledge, and evidence regarding the practice of athletic training.
38. Preceptor Responsibilities: A preceptor must demonstrate understanding of and compliance with the program’s policies and procedures.
39. Preceptor Qualification: A preceptor must be credentialed by the state in a health care profession (see glossary).
40. Preceptor Qualification: A preceptor must not be currently enrolled in the professional athletic training program at the institution;
41. Preceptor Qualification: A preceptor must receive planned and ongoing education from the program designed to promote a constructive learning environment.

**Program Delivery**

Program delivery includes didactic, laboratory, and clinical education courses.

42. The content of the curriculum must include formal instruction in the current version of the athletic training knowledge, skills, and abilities.
43. Formal instruction must involve teaching of required subject matter in structured classroom, clinical, or laboratory environments.
44. Students must interact with other medical and health care personnel (see glossary).
45. Clearly written current course syllabi are required for all courses that deliver content contained in the athletic training knowledge, skills, and abilities. Syllabi must be written using clearly stated objectives.
46. Clinical education must follow a logical progression that allows for increasing amounts of clinically supervised responsibility leading to autonomous practice upon graduation. The clinical education plan must reinforce the sequence of formal instruction of athletic training knowledge, skills, and clinical abilities, including clinical decision-making.
47. Clinical education must provide students with authentic, real-time opportunities to practice and integrate athletic training knowledge, skills, and clinical abilities, including decision-making and professional behaviors required of the profession in order to develop proficiency as an Athletic Trainer.
48. The variety of patient populations, care providers, and health care settings used for clinical education must be consistent with the program’s mission statement.
49. Clinical education assignments cannot discriminate based on sex, ethnicity, religious affiliation, or sexual orientation.
50. Students must gain clinical education experiences that address the continuum of care that would prepare a student to function in a variety of settings with patients engaged in a range of activities with conditions described in athletic training knowledge, skills and clinical abilities, *Role Delineation Study/Practice Analysis* and standards of practice delineated for an athletic trainer in the profession. Examples of clinical experiences must include, but should not be limited to: Individual and team sports; Sports requiring protective equipment (e.g., helmet and shoulder pads); Patients of different sexes; Non-sport patient populations (e.g., outpatient clinic, emergency room, primary care office, industrial, performing arts, military); A variety of conditions other than orthopedics (e.g., primary care, internal medicine, dermatology).
51. All clinical education sites must be evaluated by the program on an annual and planned basis and the evaluations must serve as part of the program’s comprehensive assessment plan.
52. An athletic trainer, certified, and in good standing with the BOC, and who currently possesses the appropriate state athletic training practice credential must supervise the majority of the student's clinical education. The remaining clinical education may be supervised by any appropriately state credentialed health care professional (see glossary).
53. Athletic training students must be officially enrolled in the program prior to performing skills on patients.
54. Athletic training students must be instructed on athletic training clinical skills prior to performing those skills on patients.
55. All clinical education must be contained in individual courses that are completed over a minimum of two academic years. Clinical education may begin prior to or extend beyond the institution's academic calendar.
56. Course credit must be consistent with institutional policy or institutional practice.
57. All clinical education experiences must be educational in nature. The program must have a written policy that delineates a minimum and maximum requirement for clinical hours.
58. All clinical education experiences must be educational in nature. Students must have a minimum of one day off in every seven-day period.
59. All clinical education experiences must be educational in nature. Students will not receive any monetary remuneration during this education experience, excluding scholarships.
60. All clinical education experiences must be educational in nature. Students will not replace professional athletic training staff or medical personnel.
61. The program must include provision for supervised clinical education with a preceptor (see Personnel Standards). There must be regular communication between the program and the preceptor.
62. The program must include provision for supervised clinical education with a preceptor (see Personnel Standards). The number of students assigned to a preceptor in each clinical setting must be of a ratio that is sufficient to ensure effective clinical learning and safe patient care.
63. The program must include provision for supervised clinical education with a preceptor (see Personnel Standards). Students must be directly supervised by a preceptor during the delivery of athletic training services. The preceptor must be physically present and have the ability to intervene on behalf of the athletic training student and the patient.

**Health & Safety**

64. Technical standards required for completion of the program must be clearly defined, published, approved by appropriate institutional representatives and be publicly accessible.
65. Students must read and sign the technical standards and are required to update their signature if their health status changes. Students who require accommodation to meet the technical standards must obtain verification by the authorized institutional office as defined by sponsoring institution policy that proper accommodation has been provided for the student to meet the standard.
66. Students must have documentation of immunizations appropriate for health care providers as determined by the institution.
67. An active communicable or infectious disease policy as determined by the institution must be established and made publicly available.
68. Students must read and sign the program's active communicable disease policy as described in Standard 67.
69. Athletic training students must have liability insurance that can be documented through policy declaration pages or other legally binding documents.
70. Athletic training students must have verification of completion of applicable HIPAA and/or FERPA training as determined by the institution.
71. The program must establish and ensure compliance with a written safety policy(ies) for all clinical sites regarding therapeutic equipment. The policy(ies) must include, at minimum, the manufacturer's recommendation or federal, state,
or local ordinance regarding specific equipment calibrations and maintenance. Sites accredited by the Joint Commission, AAAHC or other recognized external accrediting agencies are exempt.

72. The program must provide proof that therapeutic equipment at all sites is inspected, calibrated, and maintained according to the manufacturer’s recommendation, or by federal, state, or local ordinance.

73. Blood-borne pathogen training and procedures: Annual formal blood-borne pathogen training must occur before students are placed in a potential exposure situation. This includes placement at any clinical site, including observational experiences.

74. Blood-borne pathogen training and procedures: A detailed post-exposure plan that is consistent with the federal standard and approved by appropriate institutional personnel must be provided to the students.

75. Blood-borne pathogen training and procedures: Blood-borne pathogen policies must be posted or readily available in all locations where the possibility of exposure exists and must be immediately accessible to all current students and program personnel including preceptors.

76. Blood-borne pathogen training and procedures: Students must have access to and use of appropriate blood-borne pathogen barriers and control measures at all sites.

77. Blood-borne pathogen training and procedures: Students must have access to, and use of, proper sanitation precautions (e.g. hand washing stations) at all sites.

78. All sites must have a venue-specific written Emergency Action Plan (EAP) that is based on well-established national standards or institutional offices charged with institution-wide safety (e.g. position statements, occupational/environmental safety office, police, fire and rescue).

79. The program must have a process for site-specific training and review of the EAP with the student before they begin patient care at that site.

80. Students must have immediate access to the EAP in an emergency situation.

Financial Resources

81. The program must receive adequate, equitable, and annually available resources necessary to meet the program’s size and documented mission and outcomes. Funding must be commensurate with other comparable health care programs. If no such similar program exists at the institution, then benchmark with health care programs at peer institutions.

82. Funding must be available for the following: Expendable supplies; Equipment maintenance and calibration; Course instruction; Operating expenses; Faculty professional development; Capital equipment.

Facilities and Instructional Resources

83. The classroom and laboratory space must be sufficient to deliver the curriculum and must be available for exclusive use during normally scheduled class times.

84. The number and quality of instructional aids must meet the needs of the program.

85. The equipment and supplies needed to instruct students in the current athletic training knowledge, skills, and clinical abilities must be available for formal instruction, practice, and clinical education.

86. Library and other Information Sources: Students must have reasonable access to the information resources needed to adequately prepare them for professional practice. This includes current electronic or print editions of books, periodicals, and other reference materials and tools related to the program goals.

87. Offices must be provided for program staff and faculty on a consistent basis to
allow program administration and confidential student counseling.

**Operational Policies and Fair Practices**

88. Program Admission, Retention and Advertisement: If the program uses a secondary selective admission process, this must be stated in university publications. The standards and criteria must be identified and publicly accessible.
89. All program documents must use accurate terminology of the profession and program offered (e.g., BOC certification, athletic training student, and the program title of athletic training).
90. All academic tuition, fees, and other required program specific costs incurred by the student must be publicly accessible in official institutional documents.

**Program Description & Requirements**

91. Athletic training faculty and students must have a clearly written and consistent description of the academic curriculum available to them.
92. Athletic training faculty and students must have a clearly written and consistent description of the academic curriculum available to them. This description must include program mission, goals and objectives.
93. Athletic training faculty and students must have a clearly written and consistent description of the academic curriculum available to them. This description must include curriculum and course sequence.
94. Athletic training faculty and students must have a clearly written and consistent description of the academic curriculum available to them. This description must include program requirements for completion of the degree.
95. The institution must have a published procedure available for processing student and faculty grievances.
96. Policies and processes for student withdrawal and for refund of tuition and fees must be published in official institutional publications or other announced information sources and made available to applicants.
97. Policies and procedures governing the award of available funding for scholarships administered by the program must be accessible by eligible students.

**Student Records**

98. Program must maintain appropriate student records demonstrating progression through the curriculum.
99. Program must maintain appropriate student records. These records, at a minimum, must include blood borne pathogen training.
100. Program must maintain appropriate student records. These records, at a minimum, must include program admission application and supporting documents.
101. Program must maintain appropriate student records. These records, at a minimum, must include signed technical standards and, when applicable, the necessary accommodation plan.
102. Program must maintain appropriate student records. These records, at a minimum, must include academic progression (e.g., grade tracking/completion forms, advisement forms).
103. Program must maintain appropriate student records. These records, at a minimum, must include remediation and disciplinary actions (when applicable).
104. Program must maintain appropriate student records. These records, at a minimum, must include clinical education experiences.
105. Student records must be stored in a secure location(s), either electronic or in print, and be accessible to only designated program personnel.

**Distance Learning Sites (if applicable)**

106. All distance learning sites must provide comparable and equally accessible learning and instructional equipment and supplies for classroom and laboratory instruction and student assessment.

107. All educational technology used for formal instruction and assessment must be comparable and equally accessible to all students regardless of location.

108. At all distance or remote education sites, all equipment and supplies as listed above used for classroom and laboratory instruction and assessment must be comparable and equally accessible to all students regardless of location.

109. At all distance or remote education sites, all library and other information resources used for classroom and laboratory instruction and student assessment must be comparable and equally accessible to all students regardless of location.

**Glossary:**

**Academic plan:** The document that encompasses all aspects of the student’s classroom, laboratory, and clinical experiences. Also called a specimen program or curriculum plan.

**Academic year:** Two academic semesters or three academic quarters.

**Affiliation agreement:** formal, written document signed by administrative personnel, who have the authority to act on behalf of the institution or affiliate, from the sponsoring institution and affiliated site. This agreement defines the roles and responsibilities of the host site, the affiliate, and the student. Same as the memorandum of understanding.

**Appropriate administrative authority:** Individuals identified by the host institution and, when applicable, the affiliate who have been authorized to enter an agreement on behalf of the institution or affiliate. The individuals having appropriate administrative authority may vary based on the nature of the agreement.

**Assessment plan:** See Comprehensive Assessment Plan

**Clinical education:** The application of athletic training knowledge, skills, and clinical abilities on an actual patient base that is evaluated and feedback provided by a preceptor.

**Clinical site:** A physical area where clinical education occurs.

**Communicable disease:** A contagion that may be directly transmitted from person-to person or by a person from an inert surface.

**Comprehensive Assessment Plan:** The process of identifying program outcomes, collecting relevant data, and analyzing those data, then making a judgment on the efficacy of the program in meeting its goals and objectives. When applicable, remedial or corrective changes are made in the program.

**Course/coursework:** Courses involve classroom (didactic), laboratory, and clinical learning experience.

**Curricular Plan:** See Academic Plan
**Degree**: The award conferred by the college or university that indicates the level of education (baccalaureate or masters) that the student has successfully completed in athletic training.

**Direct patient care**: The application of athletic training knowledge, skills, and clinical abilities on an actual patient.

**Distant learning site**: Classroom and laboratory instruction accomplished with electronic media with the primary instructor at one institution interacting with students at other locations. Instruction may be via the internet, telecommunication, video link, or other electronic media. Distance education does not include clinical education or the participation in clinical experiences.

**Emergency Action Plan**: A venue-specific "blueprint" used for the management of medical emergencies.

**Faculty**: An individual who has full faculty status, rights, responsibilities, privileges, and full college voting rights as defined by institution policy and that are consistent with similar positions at the institution necessary to provide appropriate program representation in institutional decisions. Additionally, faculty are defined as follows:

- **Core faculty** – Administrative or teaching faculty devoted to the program that has full faculty status, rights, responsibilities, privileges, and full college voting rights as defined by the institution. This person is appointed to teach athletic training courses, advise and mentor students in the AT program. At minimum, this must include the Program Director and one (1) additional faculty member. Core full-time faculty report to and are evaluated and assigned responsibilities exclusively by the administrator (Chair or Dean) of the academic unit in which the program is housed.

- **Associated faculty** – Individual(s) with a split appointment between the program and another institutional entity (e.g., athletics or another institutional department). These faculty members are evaluated and assigned responsibilities by two different supervisors.

- **Adjunct faculty** - Individual contracted to provide course instruction on a full-course or partial-course basis, but whose primary employment is elsewhere inside or outside the institution. Adjunct faculty may be paid or unpaid.

**Fees**: Institutional charges incurred by the student other than tuition and excluding room and board.

**Goals**: The primary or desired results needed to meet an outcome. These are usually larger and longer term than objectives.

**Health Care Professional**: Athletic Trainer, Chiropractor, Dentist, Registered Dietician, Emergency Medical Technician, Nurse Practitioner, Nutritionist, Occupational Therapist, Optometrist, Orthotist, Paramedic, Pharmacist, Physical Therapist, Physician Assistant, Physician (MD/DO), Podiatrist, Prosthetist, Psychologist, Registered Nurse, or Social Worker. These individuals must hold a current credential to practice the discipline in the state and whose discipline provides direct patient care in a field that has direct relevancy to the practice and discipline of Athletic Training. These individuals may or may not hold formal appointments to the instructional faculty.

**Higher education accrediting agency**: An organization that evaluates post-secondary educational institutions.
**Infectious disease**: A disease caused by microorganisms entering the body. An infectious disease may or may not be contagious.

**Laboratory**: A setting where students practice skills on a simulated patient (i.e., role playing) in a controlled environment.

**Major**: The designation as a major must be consistent with institutional and system wide requirements. Institutional documents (e.g., catalog, web pages) must list athletic training as a major.

**Medical director**: The physician who serves as a resource regarding the program's medical content. There is no requirement that the medical director participates in the clinical delivery of the program.

**Memorandum of understanding (MOU)**: Similar to an affiliation agreement, but tends not to include legally-binding language or intent.

**Monetary remuneration**: Direct cash payment received by students for athletic training services and/or time (e.g., hourly wage, work study).

**Objectives**: Sub-goals required to meet the larger goal. Generally objectives are more focused and shorter-term than the overriding goal.

**Official publication**: An institutional document (printed or electronic) that has been approved by the appropriate institutional personnel.

**Outcome (program)**: The quantification of the program's ability to meet its published mission. The outcome is generally formed by multiple goals and objectives. For example, based on the evaluation of the goals associated with the outcomes, each outcome may be measured as "met," "partially met," or "not met."

**Outcome assessment instruments**: A collection of documents used to measure the program's progress towards meeting its published outcomes. Examples of outcomes assessment instruments include course evaluation forms, employer surveys, alumni surveys, student evaluation forms, preceptor evaluation forms, and so on.

**Physician**: A medical doctor (MD) or doctor of osteopathic medicine (DO) who possesses the appropriate state licensure.

**Preprofessional student**: A student who is not formally admitted into the program. Preprofessional students may be required to participate in non-patient activities as described by the term Directed Observation Athletic Training.

**Preceptor**: A certified/licensed professional who teaches and evaluates students in a clinical setting using an actual patient base.

**Professional development**: Continuing education opportunities and professional enhancement, typically is offered through the participation in symposia, conferences, and in-services that allow for the continuation of eligibility for professional credentials.

**Program Director**: The full-time faculty member of the host institution and a BOC Certified Athletic Trainer responsible for the implementation, delivery, and administration of the AT program.
**Release time (reassigned work load):** A reduction in the base teaching load to allow for the administrative functions associated with functioning as the Program Director and/or clinical coordinator.

**Retention:** Matriculating through the AT program culminating in graduation.

**Retention rate:** A time-based measure of the number of students who are enrolled at the start of the period being studied (e.g., 1 year, 4 years) versus those enrolled at the end of the period. Retention rate is calculated as: number at end/number at start * 100.

**Secondary selective admissions process:** A formal admission process used for acceptance into the AT major following acceptance into the institution. Secondary selective admissions is optional and determined by the program.

**Similar academic institution (Syn: Peer institution):** Institutions of comparable size, academic mission, and other criteria used for comparing metrics. Many institutions publish a list of peer institutions.

**Sponsoring institution:** The college or university that offers the academic program and awards the degree associated with the athletic training program.

**Stakeholder:** Those who are affected by the program’s outcomes. Examples include the public, employers, the Board of Certification, Inc., and alumni.

**Team physician:** The physician (MD or DO) responsible for the provision of health care services for the student athlete. The team physician may also be the medical director; however, this is not required by the Standards.

**Technical standards:** The physical and mental skills and abilities of a student needed to fulfill the academic and clinical requirements of the program. The standards promote compliance with the Americans with Disabilities Act (ADA) and must be reviewed by institutional legal counsel.
## BACHELOR OF SCIENCE IN ATHLETIC TRAINING

*(Minimum 121 credit hours required)*

<table>
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### RELIGION CORE

**DEVELOPING BIBLICAL FAITH/LIFESTYLE**

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<td>Message of the New Testament</td>
<td>3</td>
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<tr>
<td>BIBL-111</td>
<td>Message of the Old Testament</td>
<td>3</td>
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<tr>
<td>THEO-230 Intro. to Theology</td>
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<tr>
<td>THEO-231 Intro. to Christian Ethics</td>
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*Christian Service is not a course; the hours are earned by a combination of class, group, and individual service learning experiences.*

SUBTOTAL (12 hours) .........

### LEE UNIVERSITY FRESHMAN EXPERIENCE

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<td>LEEU-101</td>
<td>Freshman Seminar: Gateway (1) (Fall)</td>
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<tr>
<td>LEEU-102A</td>
<td>Global Perspectives Seminar (1) (Spring)</td>
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<tr>
<td>LEEU-102B</td>
<td>Foundations of Benevolence (1) (Spring)</td>
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SUBTOTAL (3 hours) ..........

### GENERAL EDUCATION CORE

**ACQUIRING FUNDAMENTAL ACADEMIC SKILLS**

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<td>OR ENGL-106 (3) and ENGL-110 (3)</td>
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<td>OR ENGL-110 (3) [Depends on placement]</td>
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**EXPLORING THE HUMANITIES**

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<td>HUMN-202</td>
<td>Rise of Europe</td>
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<td>HUMN-301</td>
<td>Foundations of Modern World</td>
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<td>HUMN-302</td>
<td>Modern Western Culture</td>
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<td>HIST-221 / 222</td>
<td>Western Civilization I, II</td>
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<td>ENGL-221</td>
<td>Western Lit: Ancient to Renaissance</td>
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<tr>
<td>ENGL-222</td>
<td>Western Lit: Enlightenment to Postmodern</td>
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<td>ARTS-244 / 245</td>
<td>Art History I, II</td>
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<td>MUHL-211</td>
<td>Music in Culture</td>
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<td>PHIL-241</td>
<td>Introduction to Philosophy (3) (recommended)</td>
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<td>THEA-201</td>
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**UNDERSTANDING CONTEMPORARY SOCIETY**

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<td>PSYC-200</td>
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<td>HIST-212</td>
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<td>OR PLSC-250</td>
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<td>SOCI-200</td>
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<td>OR ECON-200</td>
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**SEEKING A GLOBAL PERSPECTIVE**

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<td>LING-201</td>
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SUBTOTAL (28/34 hours) ..........

### SPECIALTY AREA

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<td>ATEP-115L</td>
<td>Basic Concepts of Fitness Lab</td>
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<td>Intro to the Ath. Training Profession</td>
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<td>Care &amp; Prevention of Athletic Injuries</td>
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<td>Pre-Professional Practicum</td>
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<td>ATEP-300</td>
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<td>ATEP-311</td>
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<td>ATEP-380</td>
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<td>ATEP-391</td>
<td>Pharmacology for Athletic Trainers</td>
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<td>ATEP-400</td>
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<td>ATEP-401</td>
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<td>ATEP-410</td>
<td>Res. &amp; Special Topics in A.T.</td>
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<td>ATEP-499</td>
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<td>HSCI-344</td>
<td>Physiology of Exercise I</td>
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<td>HSCI-361</td>
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<td>PHED-350</td>
<td>Psych. Sport &amp; Human Performance</td>
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SUBTOTAL (51 hours) ..........

### COLLATERAL REQUIREMENTS

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<td>CHEM-111</td>
<td>General Chemistry I</td>
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<td>HLTH-391</td>
<td>Nutrition for Health &amp; Performance</td>
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<td>HSCI-292</td>
<td>Intro Human Anatomy &amp; Physiology I</td>
<td>4</td>
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<td>HSCI-293</td>
<td>Intro Human Anatomy &amp; Physiology II</td>
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<td>HSCI-398</td>
<td>Medical Terminology</td>
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<td>Exercise Testing &amp; Prescription</td>
<td>3</td>
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<td>MATH-111</td>
<td>College Algebra</td>
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<td>PHED-495</td>
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SUBTOTAL (27 hours) ..........

### ACADEMIC ASSESSMENT

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<td>Academic Assessment</td>
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*Approved for 2014-2015*
SUGGESTED FOUR YEAR SEQUENCE OF STUDY FOR
BACHELOR OF SCIENCE IN ATHLETIC TRAINING

(The 80-clock-hour Christian Service requirement is not listed, but is spread throughout the four years.)

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<td>College Writing/Workshop</td>
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<td>Rhetoric and Research</td>
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<td></td>
<td>Message of New and Old Testament</td>
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<td>College Algebra</td>
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<td>U S History/Government Option</td>
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<td></td>
<td>Chemistry (101 or 111)</td>
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<td></td>
<td>Human Anatomy &amp; Physiology I</td>
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<td>Basic Concepts of Fitness</td>
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<td>Medical Terminology</td>
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<td></td>
<td>Practicum II</td>
<td>1</td>
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<tr>
<td></td>
<td>Orthopaedic Evaluation I</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Orthopaedic Evaluation II</td>
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<tr>
<td></td>
<td>Kinesiology</td>
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<td>Therapeutic Modalities</td>
<td>3</td>
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<td>Therapeutic Exercise</td>
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<td>Psych of Sport &amp; Human Performance</td>
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<td>Intro. to Christian Ethics</td>
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<td>Foundations of Western Culture</td>
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<td>Humanities Option (PHI 241 recommended)</td>
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<td>Intro to Human Anatomy &amp; Physiology I and II</td>
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<td>Nutrition for Health &amp; Performance</td>
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<td>Language &amp; Culture</td>
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<td>Faith and Practice</td>
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<td>Contemporary Society Option</td>
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<td>Practicum III</td>
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<td>Practicum IV</td>
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<td>Research Methods/Special Topics in Ath.Training</td>
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<td>Admin/Superv of Athletic Training Programs</td>
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<td>Pathophysiology</td>
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<td>Pharmacology for Athletic Trainers</td>
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<td>Senior Seminar</td>
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Appendix G

Common References Used in the Development of the BOC Certification Exam

• AAOS Emergency Care and Transportation of the Sick and Injured, Gulli, Jones and Bartlett.
• AAOS First Responder: Your First Response in Emergency Care, Schottke, Jones and Bartlett.
• ACSM’s Exercise Management for Persons with Chronic Diseases and Disabilities, Durstine and Moore, Human Kinetics.
• Advanced Sports Nutrition, Benardot, Human Kinetics.
• Athletic Injury Assessment, Booher and Thibodeau, McGraw-Hill Higher Education.
• Athletic Taping and Bracing, Perrin, Human Kinetics.
• Athletic Training and Sports Medicine (AAOS), Starkey and Johnson, Jones and Bartlett.
• Athletic Training Management: Concepts and Applications, Rankin, and Ingersoll, McGraw-Hill.
• Basic Biomechanics, Hall, Mosby-Year Book, Inc.
• Clinically Oriented Anatomy, Moore and Dalley, Lippincott, Williams & Wilkins.
• CPR/AED for the Professional Rescuer, American Red Cross, StayWell.
• Complete Emergency Care, American Safety and Health Institute, Human Kinetics.
• Concepts of Athletic Training, Pfeiffer and Mangus, Jones and Bartlett.
• Counseling in Sports Medicine, Ray and Wiese-Bjornstal, Human Kinetics.
• Documentation for Athletic Training, Konin and Frederick, Slack, Inc.
• Essential Clinical Anatomy, Moore and Agur, Lippincott, Williams & Wilkins.
• Essential Medical Terminology, Stanfield, et al., Jones and Bartlett.
• Evaluation of Orthopedic and Athletic Injuries, Starkey and Ryan, F.A. Davis Company.
• Exercise Physiology: Energy, Nutrition, and Human Performance, McArdle, et al., Lippincott, Williams & Wilkins.
• Foundations of Athletic Training, Anderson, et al., Lippincott, Williams & Wilkins.
• General Medical Conditions in the Athlete, Cuppett and Walsh, Elsevier-Mosby, Inc.
• Management of Bloodborne Infections in Sport, Zeigler, Human Kinetics.
• Management Strategies in Athletic Training, Ray, Human Kinetics.
• Medical Terminology for Health Professionals, Ehrlich and Schroeder, Thomson Delmar Learning.
• Modalities for Therapeutic Intervention, Michlovitz and Nolan, F.A. Davis Company.
• Musculoskeletal Assessment: Joint Range of Motion & Manual Muscle Strength, Clarkson, Lippincott, Williams & Wilkins.
• NATA Position & Consensus Statements, National Athletic Trainers’ Association.
• NSCA’s Essentials of Strength Training and Conditioning, Baechle and Earle, Human Kinetics.
• Orthopedic Physical Assessment, Magee, Saunders Elsevier.
• Pharmacology in Rehabilitation, Ciccone, F.A. Davis Company.
• Physiology of Sport and Exercise, Wilmore, et al., Human Kinetics.
• Practical Sports Nutrition, Burke, Human Kinetics.
• Principles and Practice of Primary Care Sports Medicine, Garrett, et al., Lippincott, Williams & Wilkins.
• Principles of Human Anatomy, Tortora, John Wiley & Sons.
• Principles of Pharmacology for Athletic Trainers, Hougum, et al., Slack, Inc.
• Rehabilitation Techniques in Sports Medicine, Prentice, McGraw-Hill.
• Special Tests for Orthopedic Examination, Konin, et al., Slack, Inc.
• Sports and Exercise Nutrition, McArdle, et al., Lippincott, Williams & Wilkins.
• Sports Emergency Care: A Team Approach, Rehberg, Slack, Inc.
• Team Physician’s Handbook, Mellion, et al., Hanley & Belfus, Inc.
• Techniques in Musculoskeletal Rehabilitation, Prentice and Voight, McGraw-Hill Medical Publishing Division.
• Therapeutic Exercise: Foundations and Techniques, Kisner and Colby, F.A. Davis Company.
• Therapeutic Exercise: Techniques for Intervention, Bandy and Sanders, Lippincott, Williams & Wilkins.
• Therapeutic Modalities, Starkey, F.A. Davis Company.
• Wound Care Essentials: Practice Principles, Baranoski and Ayello, Lippincott, Williams & Wilkins.
• Writing SOAP Notes with Patient/Client Management Formats, Kettenbach, F.A. Davis Company.
Appendix H
Application for Admission

Athletic Training Education Program
Department of Health, Exercise Science, and Secondary Education
Lee University
Application for Admission

If you are an Athletic Training major (ATEP) and meet all of the following criteria, you may apply for regular admission to the Athletic Training Education Program. You may apply for provisional admission if you have fulfilled one, two, or three criteria. Provisional admission simply means that you might be granted probationary admission and all provisional issues must be resolved (or an acceptable plan for meeting the criteria be accepted by the admissions committee) before the candidate can progress with the program.

- You have an overall GPA of 2.75 at the time the application is submitted;
- You have achieved a 85% on entrance exam;
- You have completed a background check and waiver;
- You have successfully completed ATEP 200 with a final grade not lower than a B-;
- You have successfully completed HSCI 292 or BIOL 109 with a final grade not lower than a C-;
- You have successfully completed ATEP 353 with a final grade not lower than a B- and maintained a current Professional Rescuer card;
- You have secured a recommendation from a BOC Certified Athletic Trainer who knows the student and his/her interest and commitment to athletic training. The Program Director may not be used for a recommendation.

Application Process
1. Complete the application.
2. Complete the Technical Standards for Admission form* and attach one copy.
3. Have two professionals (at least one ATC) complete a Recommendation for Admission form* and attach both forms.
4. Read and sign the Confidentiality Form and Policy & Procedure Form.*
5. Attach unofficial copies of your transcripts from all colleges attended.
6. Attach a Degree Audit of your studies at Lee University.
7. Compose a typewritten essay regarding your interest in athletic training as a career. Feel free to include things such as your reasons for pursuing athletic training, why you chose the athletic training program at Lee University, or where you want go with your chosen career.
8. If a Student at Lee University, you have uploaded all aforementioned items on Evalue (electronic documentation system).

*Forms can be found in the Student Handbook and/or on the ATEP website
Athletic Training Education Program
Application for Admission

<table>
<thead>
<tr>
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<th>Student ID</th>
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<table>
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| (______) | (______) | (______) |
| Local Phone | Home Phone | Alternate Phone (Cell, FAX, etc.) |

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<table>
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Ethnic Origin (optional)
- [ ] American Indian
- [ ] Hispanic
- [ ] White – Not Hispanic
- [ ] Black, Not Hispanic
- [ ] Asian/Pacific Islander
- [ ] Other

I have read the requirements for admission to the Athletic Training Education Program at Lee University and assume full responsibility for meeting them. I understand that until all requirements have been met I cannot be granted full admission to the ATEP and cannot progress in the program.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
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</thead>
<tbody>
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Appendix I

FINGERPRINTING AND BACKGROUND CHECK
Athletic Training Education Program

Tennessee law requires that all students wishing to be admitted to the Athletic Training Education Program must first be fingerprinted and have a background check. This must be completed before admittance to the Athletic Training Education Program. Additionally, students are responsible for the cost of the background check and fingerprinting.

Here is the procedure:

Call the following number to register to be fingerprinted: 1-855-226-2937 or go to www.L1enrollment.com. Click on the Tennessee map – click online scheduling – click on language preference – type in your name – select non-DCS childcare/adoption provider – select Childcare-Related Worker (private) and go from there.

You will be asked for your ORI number – this is a code that will insure that your report will be sent to Lee University. The Lee University ORI number is: TNCC06012.

If you are asked for a Transaction Type or Transaction Number, use the code “DP” which indicates you are a university student.

When you are asked for the agency, indicate “Applicant Pay” since you are responsible for the cost. Applicants may pay for the transaction by debit or credit card by calling 1-855-226-2937 OR at www.L1enrollment.com.

The cost of a background check is between $50-75.

The closest places to have your fingerprints taken are:
**UPS Store at 114 Stuart Rd. Cleveland (423-478-1141)**

UPS Store at 2288 Gunbarrel Road, Chattanooga (423-499-4440) The store is in the “Best Buy” / “Hobby Lobby” shopping center, near McAllister’s Deli. You do not have to have an appointment – you may go during store hours:

- Monday – Friday (8:30 – 7:00)
- Saturday (10:00 – 4:00)

**AIM Mail Center** at 412 S. White Street, Athens (423-507-9736) during store hours:

- Monday – Friday (9:00 – 5:00)
- Saturday (10:00 – 2:00)

Typically, the results should be received by Lee University in 10 business days. Please complete the procedure at least two weeks before you wish to be admitted to the Athletic Training Education Program. This time frame will allow sufficient time for the Athletic Training Education Office to process your complete application.
Athletic Training Education Program

APPLICANT WAIVER

I am applying for admission to the Athletic Training Education Program at Lee University. By signing this waiver, I am agreeing to the release of any and all of my criminal history that may be in the TBI and FBI criminal databases. Further, I will disclose any arrests, convictions, etc. to the Medical Director and Program Director of Athletic Training Education Program within ten (10) business days of the occurrence.

__________________________________________  __________________________
Applicant Name (Printed)                          Student ID Number

__________________________________________
Applicant Signature

__________________________________________
Date

NOTE: The information disclosed in the background report will be handled according to FERPA guidelines.

__________________________________________
For Office Use Only

Date of Background Check: ____________________  Status __________

Notes: ______________________________________

__________________________________________

__________________________________________
Appendix K

STUDENT ATHLETIC TRAINER CONFIDENTIALITY AGREEMENT

Whereas, ______________________, hereinafter referred to as “Student Athletic Trainer” is enrolled in the Athletic Training Education Program at Lee University in the Department of Athletics; and

Whereas, because of the Athletic Training Student’s position in the above mentioned department, the Student Athletic Trainer is exposed to certain confidential information and/or other information regarding the Athlete Medical Records and/or regarding the overall operations of the department that are of a highly confidential nature; and

Whereas, the Athletic Training Student’s has either been given this information in his or her position as an Employee and/or will be given certain information in his or her position as a Student Athletic Trainer of Lee University; and

Whereas, as an additional condition to this Athletic Training Student’s continued employment and as a part of the consideration for being an employee of Lee University and receiving compensation of various sorts from Lee University, the Student Athletic Trainer agrees that upon termination of his or her association with Lee University that the he/she shall deliver to Lee University any and all notes, records, memoranda, and/or other papers relative to Lee University’s operations and/or the specific departments operations that are of a confidential nature; and

Whereas, the Athletic Training Student further agrees not to divulge or pass on any of this confidential information to any other school, university, and/or other individual or entity for any reason without the prior written consent of Lee University; this being for the purpose of maintaining the confidentiality of information and

Whereas, the Athletic Training Student understands and agrees that to divulge any confidential information that this Athletic Training Student has and/or is aware of may result in a formal reprimand being placed in the Athletic Training Student’s file and/or may result in employment termination depending upon the specific fact circumstances and specific case; and

Whereas, all parties understand and agree that this document is executed for the purpose of furthering the educational goals and/or objectives and/or the spiritual goals and/or objectives of Lee University, its employees and/or students.

______________________________________________________
Signature

______________________________________________________
Date
Appendix L

Technical Standards for Admission

The Athletic Training Educational Program at Lee University is a rigorous and intense program that places specific requirements and demands on the students enrolled in the program. An objective of this program is to prepare graduates to enter a variety of employment settings and to render care to a wide spectrum of individuals engaged in physical activity. These technical standards set forth by the Athletic Training Educational Program establish the essential qualities considered necessary for students admitted to this program to achieve the knowledge, skills, and competencies of an entry-level athletic trainer as well as meet the expectations of the program’s accrediting agency (Commission on Accreditation of Athletic Training Education [CAATE]).

All students admitted to the Athletic Training Educational Program must meet the following abilities and expectations. In the event a student is unable to fulfill these technical standards, with or without reasonable accommodation, the student will not be admitted into the program. Compliance with the program’s technical standards does not guarantee a student’s eligibility for the BOC certification exam.

Candidates for selection to the Athletic Training Educational Program must demonstrate:

1. Mental capacity to assimilate, analyze, synthesize, integrate concepts and problem solve to formulate assessment and therapeutic judgments and to be able to distinguish deviations from the norm;

2. A combination of strength, dexterity, mobility, and coordination, sufficient postural and neuromuscular control, sensory function, and coordination to provide safe, quality care in performing standard tasks and perform appropriate physical examinations using accepted techniques and administering necessary medical treatments, accurately, safely and efficiently use equipment and materials during the assessment and treatment of patients and respond rapidly to meet patient and situational needs;

3. Ability to communicate effectively and sensitively with patients and colleagues, including individuals from different cultural and social backgrounds; this includes, but is not limited to, the ability to establish rapport with patients and communicate judgments and treatment information effectively. Students must be able to understand and speak the English language at a level consistent with competent professional practice;

4. Ability to record the physical examination results and a treatment plan clearly and accurately;
5. Capacity to maintain composure and continue to function well during periods of high stress;

6. Perseverance, diligence and commitment to complete the athletic training education program as outlined and sequenced;

7. Flexibility and the ability to adjust to changing situations and uncertainty in clinical situations;

8. Affective skills and appropriate demeanor and rapport that relate to professional education and quality patient care.

Candidates for selection to the athletic training educational program will be required to verify they understand and meet these technical standards or that they believe that, with certain accommodations, they can meet the standards. The Disability Services Program will evaluate a student who states he/she could meet the program’s technical standards with accommodation and confirm that the stated condition qualifies as a disability under applicable laws.

If a student states he/she can meet the technical standards with accommodation, the University will determine whether it agrees that the student can meet the technical standards with reasonable accommodation. Determination includes a review whether the accommodations requested are reasonable, taking into account whether accommodation would jeopardize clinician/patient safety, or the educational process of the student or the institution, including all coursework, clinical experiences and internships is deemed essential for graduation.
Technical Standards Signature Page

Please read and sign one of the following certifications.

1. I certify that I have read and understand the technical standards for selection listed above and I believe to the best of my knowledge that I meet each of these standards without accommodation. I understand that if I am unable to meet these standards I will not be admitted into the program.

   ___________________________  ____________________
   Printed name of Applicant                                      Date

   ___________________________________________  ___________________
   Signature of Applicant                                      Date

2. I certify that I have read and understand the technical standards of selection listed above and I believe to the best of my knowledge that I can meet each of these standards with certain accommodations. I will contact the Disability Services Program to determine what accommodations may be available. I understand that if I am unable to meet these standards with or without accommodations, I will not be admitted into the program.

   ___________________________  ____________________
   Printed name of Applicant                                      Date

   ___________________________________________  ___________________
   Signature of Applicant                                      Date
Appendix M

POLICY AND PROCEDURE AGREEMENT FORM

Please read the following carefully and check the appropriate column:

<table>
<thead>
<tr>
<th>STUDENT RECEIVED ACCESS TO HANDBOOK ON-LINE</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDENT HAS FULLY READ AND UNDERSTANDS</td>
<td></td>
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<tr>
<td>• Competitive Admission Policies</td>
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<td>• Conduct &amp; Dress Policies</td>
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<td>• Retention, continuation, completion policies</td>
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<td>• Sports participation policies</td>
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<td>• Suspension &amp; Grievance policies</td>
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<td>• Communicable disease policy</td>
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<td>• Completion/Endorsement policy</td>
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</tbody>
</table>

Student should be aware that he/she shall abide by the course outline as indicated for timely graduation. Any aberrance to follow the course outline due to extracurricular involvements or lack of proper time management may yield in extension of the time for graduation or probation from the program. I understand my clinical rotations may exceed into my traditional “break” sessions. I understand my clinical rotations must be a priority above my extracurricular and employment opportunities.

I am aware that travel to my clinical sites is my financial responsibility (e.g. gas, vehicle maintenance etc).

I have read and understood thoroughly the Policy and Procedure Agreement Form and I agree to abide by the rules and regulation hence set forth.

___________________________________  __________________
Student Signature                      Date

___________________________________  __________________
Program Director Signature             Date

___________________________________  __________________
Clinical Coordinator Signature         Date
Appendix N

Athletic Training Education Program
Recommendation for Admission

<table>
<thead>
<tr>
<th>Name of Student</th>
<th>Student ID</th>
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</thead>
</table>

I waive my right to view the information on this form  [ ] Yes  [ ] No

<table>
<thead>
<tr>
<th>Signature of Student</th>
<th>Date</th>
</tr>
</thead>
</table>

How do you know this candidate?

1. Do you feel you know this student well enough to evaluate him/her?  [ ] Yes  [ ] No
2. Do you have any information regarding the candidate which you feel we should evaluate before admitting him/her?  [ ] Yes  [ ] No
3. Please check the following:
   a. I recommend him or her:
      [ ] Highly  [ ] Yes  [ ] With Reservations  [ ] No
   b. Verbal communication skills:
      [ ] Good  [ ] Average  [ ] Poor  [ ] No opportunity to observe
   c. Written communication skills:
      [ ] Good  [ ] Average  [ ] Poor  [ ] No opportunity to observe
   d. Interest in athletic training:
      [ ] Good  [ ] Average  [ ] Poor  [ ] No opportunity to observe

Additional comments you may wish to make about the candidate:

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
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</table>

Position or Title
Athletic Training Education Program
Recommendation for Admission

Name of Student ___________________________  Student ID ___________________________

I waive my right to view the information on this form  ☐ Yes  ☐ No

Signature of Student ___________________________  Date ___________________________

How do you know this candidate?

1. Do you feel you know this student well enough to evaluate him/her?  ☐ Yes  ☐ No
2. Do you have any information regarding the candidate which you feel we should evaluate before admitting him/her?  ☐ Yes  ☐ No
3. Please check the following:
   a. I recommend him or her:
      ☐ Highly  ☐ Yes  ☐ With Reservations  ☐ No
   b. Verbal communication skills:
      ☐ Good  ☐ Average  ☐ Poor  ☐ No opportunity to observe
   c. Written communication skills:
      ☐ Good  ☐ Average  ☐ Poor  ☐ No opportunity to observe
   d. Interest in athletic training:
      ☐ Good  ☐ Average  ☐ Poor  ☐ No opportunity to observe

Additional comments you may wish to make about the candidate:

Signature ___________________________  Date ___________________________

Position or Title ___________________________
Appendix O

Verification of Supervision and Clinical Hours Log

Please use the following form to record the hours you have accrued while under direct supervision. Make copies of the form as needed. You will need to complete a form for each certified athletic trainer that has supervised your clinical experiences. File all completed forms with the program director. Verification of supervision is only necessary in certain state licensing issues and will be done on a needed basis but the clinical hours log is required each semester.
Lee University
Athletic Training Education Program

Verification of Supervision

_______________________________________ partially fulfilled the athletic training experience requirements at ________________________ under my supervision. The athletic training experience consisted of _______ hour with the following high-risk sports:

_____________________________________________________________________

_____________________________________________________________________

The athletic training experiences were in compliance with the definition of supervision as defined in the Procedures for Certification. The beginning and ending dates of these experiences were:

__________________________________ to __________________________________

______________________________________    ______________________________

Signature                                      Certification Number

Sworn and subscribed before me this ________ day of ________________ 20______.

______________________________________    ______________________________

Notary Public (seal)                          Expiration of Commission

Please photocopy if additional copies of this form are needed.
## Verification of Supervision and Clinical Hours Log

**Name________________________**  **Course________________________**

<table>
<thead>
<tr>
<th>Date</th>
<th>Field/Clinic/TR</th>
<th>Sport name/or Patient type</th>
<th>CI</th>
<th>Daily Total</th>
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**Monthly total**

139
Appendix P

HEPATITIS A & B IMMUNIZATION

Athletic training students are, through specified course work and clinical experiences, are preparing for their profession. As with any health care professional preparation, there comes with patient contact during clinical education a risk of coming in contact with blood and other body fluids that may or may not be contaminated. Athletic trainers adhere to OSHA Universal Precautions which are designed to minimize the risk of contamination. During ATEP 200 each Athletic Training Students will learn the risks and hazards of contamination with Hepatitis. There is, however, a risk of exposure to blood and body fluid borne pathogens and all athletic training students are required to complete the Hepatitis B series or sign a waiver declining the immunization and encouraged to receive the Hepatitis A immunization. These are available all students at Lee University through the university’s Health Services.

The decision to be immunized against Hepatitis A is entirely up to each Athletic Training Student. All applicants to the ATEP at Lee University are required to complete and submit the Hepatitis A and B Immunization Form with the application for admittance to the program.

I, (print name) ________________________________________________________, have completed / will complete (circle one) the Hepatitis B series by (date) _____________.

I, (print name)_______________________________________________________ accept / decline (circle one) the Hepatitis A immunization.

______________________________________________ ________________________
Signature of Applicant Date

______________________________________________ ________________________
Signature of Provider of Hepatitis A Immunization Date

______________________________________________ ________________________
Signature of Provider of Hepatitis B Immunization Date
Appendix Q

Evaluation Forms
Lee University
Athletic Training Student Evaluation
Pre-professional Practicum

Student:_________________________ Assignment:___________ Date:___________
Evaluator:____________________________________ Title:____________________

Please use the following scale to assess the athletic training student in the following areas:

A  The objective was met and exceeded
B  The objective was fully met
C  The objective was minimally met
D  The objective was not met
E  The student did not attempt to meet this objective
F Non-applicable/Excused Omission

1. Provided timely and appropriate first-aid to injured athletes.
2. Communicated daily with the supervising ATC and upper class athletic training students.
3. Maintained accurate and current records in the computer.
4. Responded to criticism with openness and a willingness to learn from mistakes.
5. The athletic training student was punctual and in proper attire.
7. Used medical terminology correctly.
8. Maintained proper working conditions in the athletic training room.
9. Kept the athletic training kit stocked and organized.
10. Worked cooperatively with other athletic training students.
11. Was confident while performing duties.
12. Remained attentive to what was going on during practices and games.
13. Maintained a professional attitude and relationship with all concerned.
14. Demonstrated the appropriate use of prevention techniques (e.g., taping, assisting with stretching, hydration, etc.).

Based on the following scale, indicate the percentage grade you think this student should receive for professionalism this student should be assigned for this rotation:

A  = 92%  C+ = 82%  D  = 70%
B+ = 90%  C  = 78%  D- = 68%
B  = 86%  C- = 76%  F  = 67%
B- = 84%  D+ = 74%

Grade: %

Please write any comments you may have on the back of this page.

Student signature:________________________________________ Date:___________
Clinical Instructor:________________________________________ Date:___________
Program Director:________________________________________ Date:___________
Lee University
Athletic Training Student Evaluation
Practicum I

Student:_________________________ Assignment:_____________ Date:____________
Evaluator:_________________________________ Title:____________________

Please use the following scale to assess the athletic training student in the following areas:
   A  The objective was met and exceeded
   B  The objective was fully met
   C  The objective was minimally met
   D  The objective was attempted but not met
   E  The student did not attempt to meet this objective
   F  Non-applicable/Excused omission

1.  Provided timely and appropriate first-aid to injured athletes.
2.  Communicated daily with supervising ATC and upper class athletic training students.
3.  Maintained accurate and current records in the computer.
4.  Responded to criticism with openness and a willingness to learn from mistakes.
5.  The athletic training student was punctual and in proper attire.
7.  Used medical terminology correctly.
8.  Maintained proper working conditions in the athletic training room.
9.  Kept the athletic training kit stocked and organized.
10. Worked cooperatively with other athletic training students.
11. Was confident while performing duties.
12. Remained attentive to what was going on during practices and games.
13. Maintained a professional attitude and relationship with all concerned.
14. Demonstrated the appropriate use of prevention techniques (e.g., taping, assisting with stretching, hydration, etc.).

Please use the following scale to assess proficiency in the following skills:
   A  Complete proficiency in the skill, better than most students at this level
   B  Performs the skill well
   C  Performs the skill with guidance or needs improvement
   D  Unable to perform or refused to attempt the skill
   E  No opportunity to observe student performance of this skill

15.  Basic taping techniques (ankle, wrist, fingers, thumb, arch)
16.  Proper care of an open wound
17.  Follows OSHA standards
18.  Accuracy in fitting appliances
(over)
Based on the following scale, indicate the **percentage** grade this student should be assigned for this rotation: (base your grade on professionalism as well as the scores you gave them relative to the objectives they met for this rotation).

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>A</td>
<td>92%</td>
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<td>B+</td>
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<td>B</td>
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<td>B-</td>
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<td>C+</td>
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<td>C-</td>
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<td>D+</td>
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<td>D</td>
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<td>D-</td>
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<td>F</td>
<td>67%</td>
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</tbody>
</table>

Comments:

Student signature: ________________________________  Date: __________

Clinical Instructor: ________________________________ Date: __________

Program Director: ________________________________  Date: __________
Lee University
Athletic Training Student Evaluation
Practicum II

Student: __________________________ Assignment: __________ Date: __________

Evaluator: ___________________________ Title: __________________

Please use the following scale to assess the athletic training student in the following areas:
   A  The objective was met and exceeded
   B  The objective was fully met
   C  The objective was minimally met
   D  The objective was attempted but not met
   E  The student did not attempt to meet this objective
   F  Non-applicable/ Excused omission

1. Provided timely and appropriate first-aid to injured athletes.
2. Communicated daily with the supervising ATC.
3. Openly communicated with athletes concerning their health and status.
4. Evaluated injuries accurately and with confidence.
5. Provided assessment of an injury to supervising ATC when completing an evaluation.
7. Responded to criticism with openness and a willingness to learn from mistakes.
8. The athletic training student was punctual and in proper attire.
10. Used medical terminology correctly.
11. Maintained proper working conditions in the athletic training room.
12. Kept the athletic training kit stocked and organized.
13. Worked cooperatively with other athletic training students.
14. Was confident while performing duties.
15. Remained attentive to what was going on during practices and games.
16. Maintained a professional attitude and relationship with all concerned.
17. Demonstrated the appropriate use of prevention techniques.

(over)

Please use the following scale to assess proficiency in the following skills:
   A  Complete proficiency in the skill, better than most students at this level
   B  Performs the skill well
   C  Performs the skill with guidance or needs improvement
D  Unable to perform or refused to attempt the skill
E  No opportunity to observe student performance of this skill

18. Basic taping techniques (ankle, wrist, fingers, thumb, arch)
19. Proper care of an open wound
20. Follows OSHA standards
22. Proper application of modalities
23. Demonstrated appropriate and accurate evaluation techniques

Based on the following scale, indicate the percentage grade this student should be assigned for this rotation: (base your grade on professionalism as well as the scores you gave them relative to the objectives they met for this rotation).

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>A</td>
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<td>C</td>
<td>76%</td>
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<td>F</td>
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</tbody>
</table>

Grade: [%]

Comments:

Student signature: ________________________________ Date: __________
Clinical Instructor: ________________________________ Date: __________
Program Director: ________________________________ Date: __________
Please use the following scale to assess the athletic training student in the following areas:

- **A** The objective was met and exceeded
- **B** The objective was fully met
- **C** The objective was minimally met
- **D** The objective was attempted but not met
- **E** The student did not attempt to meet this objective
- **F** Non-applicable/Excused omission

1. Demonstrated initiative when performing duties and skills.
2. Worked well independently.
3. Adhered to professional standards of dress and behavior.
4. Communicated daily with the supervising Clinical Instructor.
5. Maintained accurate and current medical records.
6. Responded positively to Clinician/instructor feedback.
7. The athletic training student was punctual and in proper attire.
8. Used medical terminology (written and verbally) correctly.
9. Evaluated injuries accurately and with confidence.
10. Displayed confidence when performing skills and duties.
11. Learned actively, asking questions and researching information.
14. Maintained proper working conditions in the allied health facility by assisting with general tasks.
15. Worked cooperatively with other personnel, students, physicians, nurses and/or physical therapists.
16. Scheduled and watch a surgery with an Orthopedic physician.
17. Practiced rehab concepts related to joint mobilization, PNF, and stretching.
18. Observed and assistant (when appropriate) with a Functional Capacity Evaluation.
19. If available, assisted with aquatic rehabilitation techniques.
20. If available, practiced casting with a physician assistant.
21. If available, practiced splinting and orthoses development.
22. If available, set up and delivered treatment with Low Level Laser.
23. If available, set up and delivered treatment with CPM.
24. If available, set up, delivered treatment, and discussed isokinetic testing.

Based on the following scale, indicate the percentage grade this student should be assigned for this rotation: (base your grade on professionalism as well as the scores you gave them relative to the objectives they met for this rotation).

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<tr>
<th>Grade</th>
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Grade: [ ] %

Comments:

Student signature: ____________________________ Date: __________

Clinical Instructor: __________________________ Date: __________

Program Director: __________________________ Date: __________
Lee University
Athletic Training Student Evaluation
Practicum III

Student: ____________________________ Assignment: ______________________ Date: ____________
Evaluator: ____________________________ Title: ____________________________

Please use the following scale to assess the athletic training student in the following areas:

A  The objective was met and exceeded
B  The objective was fully met
C  The objective was minimally met
D  The objective was attempted not met
E  The student did not attempt to meet this objective
F  Non-applicable/ Excused omission

1. Provided timely and appropriate first-aid to injured athletes
2. Provided leadership for junior athletic training students
3. Openly communicated with athletes concerning their health and status
4. Evaluated injuries accurately and with confidence
5. Provided assessment of an injury to supervising ATC when completing an evaluation
6. Maintained accurate and current records and coaches report
7. Responded to criticism with openness and a willingness to learn from mistakes
8. The athletic training student was punctual and in proper attire
9. Maintained confidentiality with medical issues
10. Used medical terminology correctly
11. Maintained proper working conditions in the athletic training room
12. Kept the athletic training kit stocked and organized
13. Worked cooperatively with other athletic training students
14. Was confident while performing duties
15. Remained attentive to what was going on during practices and games
16. Maintained a professional attitude and relationship with all concerned
17. Demonstrated the appropriate use of prevention techniques
18. Evaluated injuries accurately and with confidence
19. Displayed confidence when performing skills and duties
20. Learned actively, asking questions and researching information
21. Worked cooperatively with other athletic training students coats, and supervising ATC

Please use the following scale to assess proficiency in the following skills:
   A  Complete proficiency in the skills, better than most students at this level
   B  Performs the skill well
   C  Performs the skill with guidance or needs improvement
   D  Unable to perform or refused to attempt the skill
   E  No opportunity to observe student performance of this skill

22. Basic taping techniques (ankle, wrist, fingers, thumb, arch)
23. Proper care of an open wound
24. Follows OSHA standards
25. Accuracy in fitting appliances
26. Proper application of modalities
27. Demonstrated appropriate and accurate evaluation techniques
28. Proper application of rehabilitation concepts
29. Maintains a professional appearance and attitude
30. Demonstrated knowledge of the operational procedures of the service program

I. Professionalism

Based on the following scale, indicate the percentage grade you think this student should receive for professionalism and skills performed on this rotation.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>92%</td>
</tr>
<tr>
<td>B+</td>
<td>90%</td>
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<tr>
<td>B</td>
<td>86%</td>
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<tr>
<td>B-</td>
<td>84%</td>
</tr>
<tr>
<td>C+</td>
<td>82%</td>
</tr>
<tr>
<td>C</td>
<td>78%</td>
</tr>
<tr>
<td>C-</td>
<td>76%</td>
</tr>
<tr>
<td>D</td>
<td>70%</td>
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<tr>
<td>D-</td>
<td>68%</td>
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<tr>
<td>F</td>
<td>67%</td>
</tr>
<tr>
<td>D+</td>
<td>74%</td>
</tr>
</tbody>
</table>

Grade: [Blank] %
II. **Goal Achievement**

Please indicate the percentage grade you think this student should receive for the effort toward their clinical goals and the achievement of those goals. Student may need to set additional or different goals based on the evaluation.

**Student’s semester goal(s)**

is: 

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Student’s short-term goals are:**

________________________________________________________________________

**Mid-term Achievement Percentage and Comment**

* Use percentage grades as outlined above:

```
Grade: [ ] %
```

**Additional Goal(s)**:

________________________________________________________________________

________________________________________________________________________

Comments:

________________________________________________________________________

________________________________________________________________________

```
Student signature: ____________________________ Date: ___________
Clinical Instructor: ____________________________ Date: ___________
Program Director: ____________________________ Date: ___________
```
Lee University
Athletic Training Student Evaluation
Practicum IV

Student:_________________________ Assignment:_____________ Date:____________
Evaluator:____________________________________ Title:_____________________

Please use the following scale to assess the athletic training student in the following areas:
   A  The objective was met and exceeded
   B  The objective was fully met
   C  The objective was minimally met
   D  The objective was attempted not met
   E  The student did not attempt to meet this objective
   F  Non-applicable/ Excused omission

1.  Provided timely and appropriate first-aid to injured athletes.
2.  Provided leadership for junior athletic training students.
3.  Openly communicated with athletes concerning their health and status.
4.  Evaluated injuries accurately and with confidence.
5.  Provided assessment of an injury to supervising ATC when completing an evaluation.
7.  Responded to criticism with openness and a willingness to learn from mistakes.
8.  The athletic training student was punctual and in proper attire.
10. Used medical terminology correctly.
11. Maintained proper working conditions in the athletic training room.
12. Kept the athletic training kit stocked and organized.
13. Worked cooperatively with other athletic training students.
14. Was confident while performing duties.
15. Remained attentive to what was going on during practices and games.
16. Maintained a professional attitude and relationship with all concerned.
17. Demonstrated the appropriate use of prevention techniques.
18. Evaluated injuries accurately and with confidence.
19. Displayed confidence when performing skills and duties.
20. Learned actively, asking questions and researching information.
21. Worked cooperatively with other athletic training students, coaches, and supervising ATC.

Please use the following scale to assess proficiency in the following skills:
   A  Complete proficiency in the skill, better than most students at this level
B  Performs the skill well
C  Performs the skill with guidance or needs improvement
D  Unable to perform or refused to attempt the skill
E  No opportunity to observe student performance of this skill

22. Basic taping techniques (ankle, wrist, fingers, thumb, arch)
23. Proper care of an open wound
24. Follows OSHA standards
26. Proper application of modalities
27. Demonstrated appropriate and accurate evaluation techniques
28. Proper application of rehabilitation concepts
29. Maintains a professional appearance and attitude
30. Demonstrated knowledge of the operational procedures of the service program
31. Assisted in the development of the operational budget for the ensuing year
32. Assisted in the administrative operation of the service program

Based on the following scale, indicate the percentage grade this student should be assigned for this rotation: (base your grade on professionalism as well as the scores you gave them relative to the objectives they met for this rotation).

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>92%</td>
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<tr>
<td>B+</td>
<td>90%</td>
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<tr>
<td>B</td>
<td>86%</td>
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<tr>
<td>B-</td>
<td>84%</td>
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<tr>
<td>C+</td>
<td>82%</td>
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<tr>
<td>C</td>
<td>78%</td>
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<tr>
<td>D</td>
<td>70%</td>
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<tr>
<td>D-</td>
<td>68%</td>
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<tr>
<td>C-</td>
<td>76%</td>
</tr>
<tr>
<td>F</td>
<td>67%</td>
</tr>
<tr>
<td>D+</td>
<td>74%</td>
</tr>
</tbody>
</table>

Grade: %

Comments:

I. Goal Achievement

Please indicate the percentage grade you think this student should receive for the effort toward their clinical goals and the achievement of those goals. Student may need to set additional or different goals based on the evaluation.

Student’s semester goal(s) is:

________________________________________________________________________

________________________________________________________________________
Student’s short-term goals are:

Mid-term Achievement Percentage and Comment
* Use percentage grades as outlined above:

Grade: % Additional Goal(s):

Comments:

Student signature: ____________________________ Date: __________
Clinical Instructor: __________________________ Date: __________
Program Director: __________________________ Date: __________
Lee University
Student’s Evaluation of the Clinical Instructor/Supervisor

Clinical Instructor/Supervisor: ____________________________________________

The following evaluation is to be used to evaluate the Clinical Instructors and Supervisors of Clinical Education and Field Experience components of the Lee University Athletic Training Education Program. Please be honest. This is important in evaluating the athletic training program and improves its overall effectiveness. Your evaluations will not be shared with the Clinical Instructor or Supervisor while you are attending Lee University. Instructors and supervisors will be provided your evaluation (with your name removed) after you have completed the program.

Please use the following scale to assess the Clinical Instructor in the following areas:

- **A** Very Good: Very consistent in job performance and responsibilities
- **B** Good: Usually consistent in job performance and responsibilities
- **C** Average/acceptable: Occasionally performs as per job description/responsibilities
- **D** Below average/Needs Improvement
- **E** Not effective; seldom consistent in job performance and responsibilities
- **F** Not applicable/No basis to judge/Excused Omission

I. GENERAL ROLE MODELING
   1. Is an effective professional role model for me (demonstrates knowledge, attitudes)
   2. Serves as an effective physical role model (dress, attitude, practice, etc.)
   3. Shows an interest and concern for me and willingness to give help.
   4. Serves as a mentor and advisor (facilitates my professional growth and development, etc.)

II. CLINICAL INSTRUCTORS/SUPERVISION
   5. Appears to remain up-to-date with evaluation skills, techniques, and knowledge
   6. Communicates effectively with me.
   7. Provides appropriate constructive criticism.
   8. Responds to my questions in a clear and concise manner
   9. Allows me to perform evaluations and administer treatments and provides me with formative feedback
   10. Provides me the opportunity to ask questions
   11. Provides me with an accurate critique/evaluation of the required clinical skills/competencies for my position

III. PERSONAL QUALITIES
   12. Developed a positive rapport with me.
   13. Treats me with respect and dignity.
   14. Appears approachable by students, patients, and athletes.
15. Appears honest in dealing with students, patients, and athletes.

IV. Organization and Administration
17. Demonstrates effective organization and planning.
18. Makes purposes and objectives of assignments and duties clear.
19. Discusses regularly with me athletes current status and information to be communicated to team physicians and coaches.

IV. Summary
20. Overall evaluation as a Clinical Instructor/Supervisor.
21. Overall professional ability as an athletic trainer.
22. Overall positive influence on Athletic Training Students.
23. Overall impact and influence on student athletes.
24. Positive influence for the Athletic Training Education Program.
25. Positive influence on the Lee University Athletics Program.

Please provide specific comments on the Clinical Instructor/Supervisor’s strengths and weaknesses and suggestions for improvement.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

CI/Supervisor name:___________________________ Date:__________
Student signature:_____________________________ Date:__________
Program Director:_____________________________ Date:__________
Lee University Medical Rotation evaluation of students by the Clinical Instructor/Preceptor

(might look slightly different on-line)

(Question 1 of 4 - Mandatory)

<table>
<thead>
<tr>
<th>The student:</th>
<th>A The objective was met and exceeded</th>
<th>B The objective was fully met</th>
<th>C The objective was minimally met</th>
<th>D The objective was attempted but not met</th>
<th>E The student did not attempt to meet this objective</th>
<th>F Non-applicable / Excused omission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrated initiative when performing duties and skills.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Worked well independently.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Adhered to professional standards of dress and behavior.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Student is able to follow directions</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Communicated daily with the supervising preceptor.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Maintained accurate and current medical records, if applicable.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Responded positively to preceptor feedback.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>The athletic training student</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</table>
was punctual.  

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Score</th>
<th>Score</th>
<th>Score</th>
<th>Score</th>
<th>Score</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Used medical terminology (written and verbally) correctly.</td>
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<td>Understands the roles of various allied health professionals and how they work together.</td>
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<td>Demonstrated basic understanding of anatomy and physiology regarding general medical and musculoskeletal conditions.</td>
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<td>Evaluated basic musculoskeletal injuries accurately.</td>
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<tr>
<td>Displayed confidence when performing skills and duties.</td>
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<tr>
<td>Learned actively, asking questions and researching information.</td>
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<td>Demonstrated competency in administering home exercise programs to patients.</td>
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<td>Maintained confidentiality with medical issues.</td>
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<tr>
<td>Maintained proper working conditions in the allied health facility by assisting with general tasks.</td>
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<tr>
<td>Worked cooperatively with other personnel, students, physicians, nurses and/or physical therapists.</td>
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<tr>
<td>Scheduled and watch a surgery with an Orthopeadic physician. (In the comment section, please describe this experience basic information includes surgery type, date, and key learning objectives)</td>
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<tr>
<td>Demonstrated growth in differential assessment skills.</td>
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<tr>
<td>Demonstrated growth in understanding lab results related to urine, blood, etc.</td>
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<tr>
<td>Understands various diagnostic tests ordered by physician (Including but not limited to: ECG).</td>
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</tbody>
</table>
echo cardiogram, imaging, x-rays)

Gained an understanding of different general medical conditions. (Including but not limited to: diabetes, thyroid conditions, heart disease, hypertension, anemia.)

Gained understanding for appropriate medical coding.

Based on the following scale, indicate the percentage grade this student should be assigned for this rotation: (base your grade on professionalism as well as the scores you gave them relative to the objectives they met for this rotation).

- A = 92% or better
- C+ = 82%
- D = 70%
- B+ = 90%
- C = 78%
- D- = 68%
- B = 86%
- C- = 76%
- F = 67%
- B- = 84%
- D+ = 74%

(Question 2 of 4 - Mandatory)

Grade:
Comments:  (Question 3 of 4 )

By typing my name and entering a date in the space below, I certify that I discussed this evaluation with the student on the date indicated.  (Question 4 of 4 - Mandatory )

Review your answers in this evaluation. If you are satisfied with the evaluation, click the SUBMIT button below. Once submitted, evaluations are no longer available for you to make further changes.
Appendix R

Primary, Affiliated, and Allied Site Policy and Procedures

Lee University Athletics: Jeff Mullins, Taz Kicklighter, Ai Kaechi, DeWayne Knight
Lee University Health Clinic: DeWayne Knight, Mickey Moore
Benchmark Physical Therapy: Rebecca Parker
Center for Sports Medicine and Orthopaedics: Bob Nevil, Randy Wilkes, Kim Tucker
North River Physical Therapy: (temporary not in use)
   McCallie High School: Jersey DeMarco
   Ooltewah High School: Randy Wilkes
   Grace High School: Tiffany Wilkes
   Cleveland High School: Rebecca Parker
   Alliance Physical Therapy: Mel Igot
   Advanced Physical Therapy: Cindy Moore
# Lee University Athletic Training Manual

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</tbody>
</table>
ATHLETIC TRAINING POLICY AND PROCEDURES

OBJECTIVE

The goal of Lee University Athletic Training Staff is to insure that proper and legal medical care is provided to all student athletes. In order to accomplish this goal, the cooperation of the student athlete is needed.

STAFF

The sports medicine staff is composed of certified athletic trainers as well as our team physicians.
Head Certified Athletic Trainer .................. Jeff Mullins, ATC
Certified Athletic Trainers .......................... Alex Grell, ATC
........................................................................ Kathleen Kerecman, ATC
Primary Care Team Physician ..................... Dewayne Knight, ATC, MD
Orthopedic Surgeon Team Physician ............. J.A. Dorizas, MD

In addition, the certified athletic trainers who serve as faculty members in the undergraduate athletic training program, Kelly Lumpkin PhD, ATC, and Taz Kicklighter, ATC will assist with medical coverage. Other local physicians are also associated with our staff and used on a referral basis.

FACILITIES

The main athletic training room is located in the McKenzie Athletic Training Facility. A second athletic training room is located in Walker Arena.

Walker Arena Athletic Training Room will be used primarily during event coverage for men’s and women’s basketball and volleyball. Special arrangements may be made for additional use based on specific needs, i.e. early morning practice sessions.

ATHLETIC TRAINING ROOM HOURS:

McKenzie athletic training room will be open 10:00am - 5:00pm Monday-Friday.

Treatment outside the regular hours will be arranged with the athlete. Also, practice and game schedules may also alter training room hours. These changes in hours will be posted and coaches notified.

ATHLETIC TRAINING ROOM PHONE NUMBERS

Jeff Mullins, ATC: 423-614-8462
McKenzie Training Room: 423-614-8527
Dr. DeWayne Knight: 423-614-8437 (O)
........................................................................ 423-421-8881 (C)
Ortho South: 423-624-6584
Dr. Dorizas: 423-741-3376 (C)
COORDINATION OF CARE OF INJURED OR ILL STUDENT-ATHLETES

- All student athletes who are injured or ill are required to report to an athletic trainer to receive and arrange appropriate medical attention. Lee University will not be responsible for medical expenses that were not approved and pre-arranged.

- Lee University is only financially responsible for injuries and illness that are a direct result of athletic competition.

PAYMENT OF MEDICAL EXPENSES/INSURANCE

- Any medical or dental expenses that occur outside of athletics participation cannot be covered by the University. Illnesses that occur cannot be covered if not related to athletic participation.

- Lee University cannot be financially responsible for injuries or illnesses that occur during campus summer conditioning programs.

- Lee will only be financially responsible for treatment of injuries or illnesses by our listed team physicians. If a student athlete chooses to see a physician who is not associated with Lee, the student athlete must be pre-approved by their primary insurance policy and Lee University will only be responsible for what an in-network provider would pay.

- All medical and dental expenses from an athletic related injury or illness must have prior approval, including a written authorization slip, from an athletic trainer.

- All student-athletes are required to have personal health insurance. The University has secondary insurance on all student-athletes to cover any charges for injuries/illnesses directly related to athletic participation that the athlete’s personal insurance does not pay.

- If the student-athlete’s insurance is not effective or has been dropped at the time of a medical procedure, the student-athlete will be responsible for the payment.

- All student athletes’ personal health insurance will be used as the first or primary insurance coverage for approved medical expenses. The University will pay secondarily any balances left after the primary insurance pays so that the parents or athletes bear no out of pocket expense for any athletic related medical procedures.
CONTACT LENSES AND PRESCRIBED MEDICATION:

The athletic department will not pay for contact lenses and prescribed medication for non-athletic related medical conditions. However, if a student-athlete qualifies for the Needy Student Fund, they may apply, through the compliance office, for reimbursement.

- If it is an emergency situation and you live on campus, call Campus Safety by calling 8390. If you live off campus, call 911.

- Remember, Lee University is only responsible for injuries or illnesses that are a direct result of participation in athletics.
ATHLETIC TRAINING ROOM POLICIES AND PROCEDURES

1. The Lee University athletic training room is for LU student-athletes only. It is not for the use of the general student body, family, or friends. Non-athletes should not be brought into athletic training room for injury evaluations or treatment.
2. No athlete will compete or practice without pre-participation clearance from the team physician. Also, no athlete will compete or practice without all the required forms filled out completely.
3. No cleats or dirty gear is to be worn in the athletic training room.
5. Come to the athletic training room properly dressed for treatment. If the injury is to the lower body, shorts must be worn. If it is an upper body injury, a T-shirt will be needed. Proper dress is required for treatment.
6. Come to the athletic training room in plenty of time to receive treatment or get taped. We will not be rushed because you are. Being in the Athletic Training room is no excuse to be late or miss practice and/or game.
7. Report every injury – no matter how small it may seem. DO NOT HELP YOURSELF. Wait until an athletic trainer can help you.
8. Any injuries/problems suffered by the athlete must be communicated to an ATC in a sufficient amount of time prior to next practice or competition. Delaying treatment could cause more damage
9. Instructions given by ATC(s) regarding participation during an injury must be followed. NO EXCEPTIONS!!!
10. Injuries not sustained as a result of team functions will not be the responsibility of the LU Athletic Department.
11. In order for LU’s secondary insurance policy to be valid, you must be referred to a physician by a staff ATC.
12. Wait your turn. Not everyone can be helped at once.
13. The training room is not a players’ lounge. You should only be in the training room to receive treatment or first aid.
14. Taking something from the training room without the permission of an athletic trainer is grounds for disciplinary action.
15. Absolutely no unauthorized use of rehab, therapy, athletic training equipment, tools, or supplies. Utilize equipment with care and return to its proper place when no longer in use.
16. No food or drink of any kind allowed in the treatment/rehab area.
17. Athletic Training Students shall be treated as a staff member.

THANK YOU FOR YOUR ASSISTANCE AND EFFORT IN FOLLOWING THESE RULES

CONFIDENTIALITY

Athletic Training is an Allied Health Care profession. Therefore, whenever student-athlete medical records are retained or initiated, confidentiality must be maintained according to the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Medical records shall not be left
unattended, removed from the athletic training room, or copied without the Student-Athlete’s written permission. At no time should there be discussion about an injury or injured Student-Athlete with anyone other than the medical staff. This includes parents, roommates, professors, media, other coaches, and community members. All Athletic Training Staff must always be aware of their surroundings and other persons present before discussing any confidential information.

SUBSTANCE ABUSE POLICY AND GUIDELINES

Lee University is committed to providing a healthy and safe environment for its student-athletes, coaches and staff. The abuse of alcohol or drugs by L.U. student-athletes, coaches and staff will not be condoned or tolerated. It is the responsibility of the athletic staff and coaches to see alcohol abuse and drug use does not occur and if it does, to see those involved are identified and referred for counseling to prevent further use or abuse.

Alcohol and illicit drugs can have a detrimental effect on the student-athlete’s health and performance. Anabolic steroids, considered to be a performance enhancer, have been proven to be detrimental to the student-athlete’s health. The NCAA, and all sports federations ban steroids. The use of anabolic steroids by Lee student-athletes is prohibited. The health and welfare of the student-athletes, coaches and staff is of paramount concern to the Lee University Athletic Department. It is the association’s commitment to provide an alcohol and drug-free environment. In order to meet this commitment, this comprehensive alcohol and drug usage policy and program has been developed and implemented.

OBJECTIVES

1. Provide an alcohol and drug free environment.
2. Educate student-athletes, coaches and staff members about the physical, social, psychological, financial and legal problems associated with alcohol abuse and drug use.
3. Identify student-athletes, coaches or staff members who are abusing alcohol or drugs and assure prompt counseling and treatment.
4. Provide a program to assist individuals who use or abuse drugs or alcohol to recognize their problem and be referred for counseling and rehabilitation.
EMERGENCY CARE PLAN

BASEBALL FIELD

Initiate 911 first, then dial 4444 (Campus Safety) for on-campus emergencies
McKenzie Athletic Training Center 614-8462 or 8462 on-campus

Procedures for Activating Emergency Plan

1. In the event of an injury to a student-athlete, the athletic trainer or certified first-aider should assess the extent of the injury. Always remember to wait until the official stops the game and do not move athlete until responsiveness and degree of injury are assessed.

2. If a certified first-aider feels the need for assistance they should contact the Certified Athletic Trainer if he/she is not present. The student athletic trainer and first-aider may assist in minor wound bandaging, ice bagging, and simple First Aid procedures; they can also make the necessary communications for other needed services.

3. When a situation is deemed life threatening (head, neck, or back injury or cardiac pathology) or serious in nature, one person should immediately activate EMS by the phone. The same person will instruct an assistant to clear the area located closest to the road in which the injured athlete is lying. Someone should wait third base line on 23rd St. to flag down and instruct the ambulance where to go. Make sure that the area is clear and the ambulance will have plenty of space.

4. Once the ambulance arrives, EMTs will have complete control of the scene and the situation. If transporting a student-athlete is necessary an athletic trainer or designated person should go to the hospital to provide necessary information.

Directions to Baseball Field

The Baseball field is located across from American Uniform Factory and behind Ocoee Middle School off of Ocoee St. and on 23rd St. Direct ambulance to third base line and make sure the gate is unlocked and opened.
When an **EMERGENCY** has been declared at the **BASEBALL FIELD** and an ambulance is needed during an athletic event the following protocol should be followed as closely as possible.

1. **On Field Evaluation:**  
   - **Certified Athletic Trainer:** assisted by **Student Athletic Trainer (SAT)**  
   - Retrieval of splints, ice bags, etc.

2. **Call 911**  
   - **Head Coach:** Mark Brew  
     - Use athletic trainer's cell phone or office phone in home locker room  
     - Location: across from American Uniform on the southwest corner of 23rd and Parker Street  
     - Ambulance access through double gates by visitor's dugout on 3rd base line  
     - Provide pertinent information to dispatcher

3. **Team Control**  
   - **Assistant Coach:**  
     - Direct athletes away from injured player

4. **Crowd Control**  
   - **Campus Safety:** Keep crowd off field  
   - **Athletic Director:** Keep relatives off field, but aware of situation

5. **Contact Parents**  
   - **AD/Head Coach:** Larry Carpenter or Mark Brew  
     - In life threatening situation call parents (home numbers in medical kit)  
     - In non-life-threatening situation let the athlete call home

6. **Contact Team Physician**  
   - **Supervising Athletic Trainer:** Jeff Mullins  
     - DeWayne Knight 423-421-8881

7. **Direct Paramedics**  
   - **Campus Safety:**  
     - Stand at 23rd St. to flag down EMTs and make sure 3rd base gate is open

8. **Hospital**  
   - **GA/SAT and/or Parents:**  
     - Call on duty ATC ASAP with medical status  
     - Provide necessary medical insurance information (in medical kit)

*If no ambulance is needed: SAT/GA or parent to drive. Call on duty ATC ASAP*
**SOFTBALL FIELD**

Initiate 911 first, then dial 4444 (Campus Safety) for on-campus emergencies
McKenzie Athletic Training Center 614-8462 or 8462 on-campus

**Procedures for Activating Emergency Plan**

1. In the event of an injury to a student-athlete, the athletic trainer or certified first-aider should assess the extent of the injury. Always remember to wait until the official stops the game and do not move athlete until responsiveness and degree of injury are assessed.

2. If a certified first-aider feels the need for assistance they should contact the Certified Athletic Trainer if he/she is not present. The student athletic trainer and first-aider may assist in minor wound bandaging, ice bagging, and simple First Aid procedures; they can also make the necessary communications for other needed services.

3. When a situation is deemed life threatening (head, neck, or back injury or cardiac pathology) or serious in nature, one person should immediately activate EMS by the phone. The same person will instruct an assistant to clear the area located closest to the road in which the injured athlete is lying. Someone should wait at 13th St. to flag down EMTs and instruct the ambulance where to go. Make sure that the area is clear and the ambulance will have plenty of space.

4. Once the ambulance arrives, EMTs will have complete control of the scene and the situation. If transporting a student-athlete is necessary an athletic trainer or designated person should go to the hospital to provide necessary information.

**Directions to Softball Field**

The softball field is located on the southwest corner of 18th St. and Parker St. Make sure the gate on first base line off of 18th St. in unlocked and opened.
When an **EMERGENCY** has been declared at the **SOFTBALL FIELD** and an ambulance is needed during an athletic event the following protocol should be followed as closely as possible.

1. **On Field Evaluation**
   - **Certified Athletic Trainer**: assisted by SAT
   - Retrieval of splints, ice bags, etc.

2. **Call 911**
   - **Head Coach**: Emily Russell
     - Use Athletic Trainer’s cell phone or O’Bannon Hall phone
     - Location – corner of 18th St. and Parker St.
     - Give information of situation to operator (airway, breathing, circulation, deformities, etc.)

3. **Team Control**
   - **Assistant Coach**: Direct athletes away from injured player

4. **Crowd Control**
   - **Campus Safety**: Keep crowd off field
   - **Athletic Director**: Keep relatives off field, but aware of the situation

5. **Contact Parents**
   - **AD or Head Coach**: Larry Carpenter or Emily Russell
     - In life threatening situation call parents (home numbers in medical kit)
     - In non-life-threatening situation let the athlete call home

6. **Contact Team Physician**
   - **Supervising Athletic Trainer**: Alex Grell
     - Dr. DeWayne Knight 423-421-8881

7. **Direct Paramedics**
   - **Campus Safety**:
     - Make sure 1st base gate is open
     - Stand at 18th St. to flag down ambulance

8. **Hospital**
   - **GA/SAT and/or Parents**:
     - Call on duty ATC ASAP with medical status
     - Provide necessary medical insurance information (in medical kit)

*If no ambulance is needed: SAT/GA or parent to drive. Call on duty ATC ASAP*

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**SOCCER FIELD**

Initiate 911 first, then dial 4444 (Campus Safety) for on-campus emergencies
McKenzie Athletic Training Building 614-8462 or 8462 on-campus
Procedures for Activating Emergency Plan

1. In the event of an injury to a student-athlete, the athletic trainer or certified first-aider should assess the extent of the injury. Always remember to wait until the official stops the game and do not move athlete until responsiveness and degree of injury are assessed.

2. If a first-aider feels the need for assistance they should contact the Certified Athletic Trainer if he/she is not present. The first-aider and student athletic trainer may assist in minor wound bandaging, ice bagging, and simple First Aid procedures; they can also make the necessary communications for other needed services.

3. When a situation is deemed life threatening (head, neck, or back injury or cardiac pathology) or serious in nature, one person should immediately activate EMS by the phone. The same person will instruct an assistant to clear the area located closest to the road in which the injured athlete is lying. Someone should wait by the corner of 8th and Parker to flag down EMTs and instruct the ambulance where to go. Make sure that the area is clear and the ambulance will have plenty of space.

4. Once the ambulance arrives, EMTs will have complete control of the scene and the situation. If transporting a student-athlete is necessary an athletic trainer or designated person should go to the hospital to provide necessary information.

Directions to the Soccer Field

The field is located on the northwest corner of 8th St. and Parker St. There are no gates and ambulance accessibility is optimal of all sides.
When an **EMERGENCY** has been declared at the **SOCCER FIELD** and an ambulance is needed during an athletic event the following protocol should be followed as closely as possible.

1. **On Field Evaluation**
   - **Certified Athletic Trainer**: assisted by SAT
   - Retrieval of splints, ice bags, etc.

2. **Call 911**
   - **Head Coach**: Matthew Yelton or Paul Furey
   - Use Athletic Trainer's cell phone or Livingston Hall
   - Location – Corner of 8th and Parker
   - Give information of situation to operator (airway, breathing, circulation, deformities, etc.)

3. **Team Control**
   - **Assistant Coach**: Direct athletes away from injured player

4. **Crowd Control**
   - **Campus Safety**: Keep crowd off field
   - **Athletic Director**: Keep relatives off field, but aware of situation

5. **Contact Parents**
   - **AD or Head Coach**: Larry Carpenter, Matthew Yelton or Paul Furey
     - In life threatening situation call parents (home numbers in medical kit)
     - In non-life-threatening situation let the athlete call home

6. **Contact Team Physician**
   - **Supervising Athletic Trainer**: Jeff Mullins or Kathleen Kerecman
     - Dr. DeWayne Knight 423-421-8881

7. **Direct Paramedics**
   - **Campus Safety**: Standing at corner of 8th and Parker to flag down ambulance

8. **Hospital**
   - **GA/SAT and/or Parents**: Call on duty ATC ASAP with medical status
   - Provide necessary medical insurance information (in medical kit)

*If no ambulance is needed: SAT/GA or parent to drive. Call on duty ATC ASAP*
TENNIS COURTS

Initiate 911 first, then dial 4444 (Campus Safety) for on-campus emergencies
McKenzie Athletic Training Building 614-8462 or 8462 on-campus

Procedures for Activating Emergency Plan

1. In the event of an injury to a student-athlete, the athletic trainer or certified first-aider should assess the extent of the injury. Always remember to wait until the official stops the game and do not move athlete until responsiveness and degree of injury are assessed.

2. If a first-aider feels the need for assistance they should contact the Certified Athletic Trainer if he/she is not present. The first-aider and student athletic trainer may assist in minor wound bandaging, ice bagging, and simple First Aid procedures; they can also make the necessary communications for other needed services.

3. When a situation is deemed life threatening (head, neck, or back injury or cardiac pathology) or serious in nature, one person should immediately activate EMS by the phone. The same person will instruct an assistant to clear the area located closest to the road in which the injured athlete is lying. Someone should wait at 15th St. to flag down and instruct EMTs where to go. Make sure that the area is clear and the ambulance will have plenty of space.

4. Once the ambulance arrives, EMTs will have complete control of the scene and the situation. If transporting a student-athlete is necessary an athletic trainer or designated person should go to the hospital to provide necessary information.

Directions to Tennis Courts

The Tennis Courts are located west of Parker St. on 15th St.
When an **EMERGENCY** has been declared at the **TENNIS COURTS** and an ambulance is needed during an athletic event the following protocol should be followed as closely as possible.

1. **On Field Evaluation**
   - **Certified Athletic Trainer**: assisted by SAT
   - Retrieval of splints, ice bags, etc.

2. **Call 911**
   - **Head Coach**: Patric Hynes
     - Use Athletic Trainer’s cell phone or Recreation Center phone
     - Location – on 15th St. off Parker St.
     - Give information of situation to operator (airway, breathing, circulation, deformities, etc.)

3. **Team Control**
   - **Assistant Coach**: Direct athletes away from injured player

4. **Crowd Control**
   - **Campus Safety**: Keep crowd off playing field
   - **Athletic Director**: Keep relatives off field, but aware of situation

5. **Contact Parents**
   - **AD or Head Coach**: Larry Carpenter or Patric Hynes
     - In life threatening situation call parents (home numbers in medical kit)
     - In non-life-threatening situation let the athlete call home

6. **Contact Team Physician**
   - **Supervising Athletic Trainer**: Kathleen Kerecman
     - Dr. DeWayne Knight 423-421-8881

7. **Direct Paramedics**
   - **Campus Safety**: Stand in parking lot entrance of recreation center off 15th St.

8. **Hospital**
   - **GA/SAT and/or Parents**:
     - Call on duty ATC ASAP with medical status
     - Provide necessary medical insurance information (in medical kit)

*If no ambulance is needed: SAT/GA or parent to drive. Call field on duty ATC ASAP*
WALKER ARENA

Initiate 911 first, then dial 4444 (Campus Safety) for on-campus emergencies
McKenzie Athletic Training Building 614-8462 or 8462 on-campus

Procedures for Activating Emergency Plan

1. In the event of an injury to a student-athlete, the athletic trainer or certified first-aider should assess the extent of the injury. Always remember to wait until the official stops the game and do not move athlete until responsiveness and degree of injury are assessed.

2. If a first-aider feels the need for assistance they should contact the Certified Athletic Trainer if he/she is not present. The first-aider and student athletic trainer may assist in minor wound bandaging, ice bagging, and simple First Aid procedures; they can also make the necessary communications for other needed services.

3. When a situation is deemed life threatening (head, neck, or back injury or cardiac pathology) or serious in nature, one person should immediately activate EMS by the phone. The same person will instruct an assistant to clear the area located closest to the road in which the injured athlete is lying. Someone should wait in gym parking lot across from the Humanities Center on Parker St. to flag down the EMTs and instruct the ambulance where to go. Make sure that the area is clear and the ambulance will have plenty of space.

4. Once the ambulance arrives, EMTs will have complete control of the scene and the situation. If transporting a student-athlete is necessary an athletic trainer or designated person should go to the hospital to provide necessary information.

Direction to Walker Arena

The Arena is located across from the Humanities Center, which is located on 13th St. and Parker St.
When an **EMERGENCY** has been declared at **WALKER ARENA** and an ambulance is needed during an athletic event the following protocol should be followed as closely as possible.

1. **On Field Evaluation**
   
   **Certified Athletic Trainer:** assisted by SAT
   Retrieval of splints, ice bags, etc.

2. **Call 911**
   
   **Head Coach:** Andrea Hudson, Tommy Brown or Marty Rowe
   - Use Athletic Trainer’s cell phone or hall phone by athletic offices
   - Location – Parking lot across from Humanities Center near 13th St. and Parker St.
   - Give information of situation to operator (airway) breathing, circulation, deformities, etc.)

3. **Team Control**
   
   **Assistant Coach:**
   Direct athletes away from injured player

4. **Crowd Control**
   
   **Campus Safety:** Keep crowd off gymnasium floor
   **Athletic Director:** Keep relatives off gym floor but aware of the situation

5. **Contact Parents**
   
   **AD or Head Coach:** Larry Carpenter, Andrea Hudson, Tommy Brown or Marty Rowe
   - In life threatening situation call parents (home numbers in medical kit)
   - In non-life-threatening situation let the athlete call home

6. **Contact Team Physician**
   
   **Supervising Athletic Trainer:** Alex Grell, Jeff Mullins or Kathleen Kerecman
   - Dr. DeWayne Knight 423-421-8881

7. **Direct Paramedics**
   
   **Campus Safety:**
   - Clear handicap ramp area at side entrance to gym lobby
   - Standing at Parking lot entrance to flag down ambulance and instruct them where to go

8. **Hospital**
   
   **GA/SAT and/or Parents:**
   - Call on duty ATC ASAP with medical status
   - Provide necessary medical insurance information (in medical kit)

*If no ambulance is needed: SAT/GA or parent to drive. Call on duty ATC ASAP*
CARROLL COURTS

Initiate 911 first, then dial 4444 (Campus Safety) for on-campus emergencies
McKenzie Athletic Training Center 614-8462 or 8462 on-campus

Procedures for Activating Emergency Plan

1. In the event of an injury to a student-athlete, the athletic trainer or certified first-aider should assess the extent of the injury. Always remember to wait until the official stops the game and do not move athlete until responsiveness and degree of injury are assessed.

2. If a certified first-aider feels the need for assistance they should contact the Certified Athletic Trainer if he/she is not present. The student athletic trainer and first-aider may assist in minor wound bandaging, ice bagging, and simple First Aid procedures; they can also make the necessary communications for other needed services.

3. When a situation is deemed life threatening (head, neck, or back injury or cardiac pathology) or serious in nature, one person should immediately activate EMS by the phone. The same person will instruct an assistant to clear the area located closest to the road in which the injured athlete is lying. Someone should wait at 13th St. to flag down EMTs and instruct the ambulance where to go. Make sure that the area is clear and the ambulance will have plenty of space.

4. Once the ambulance arrives, EMTs will have complete control of the scene and the situation. If transporting a student-athlete is necessary an athletic trainer or designated person should go to the hospital to provide necessary information.

Directions to Carroll Courts
(Practice Soccer Field)

The field is located off of 20th St. on Cherry St. Enter field through baseball back-stop fenced in area.
When an **EMERGENCY** has been declared at the **CARROLL COURTS** and an ambulance is needed during an athletic event the following protocol should be followed as closely as possible.

1. **On Field Evaluation**
   - **Certified Athletic Trainer:** assisted by SAT
   - Retrieval of splints, ice bags, etc.

2. **Call 911**
   - **Head Coach:** Matthew Yelton or Paul Furey
     - Use Athletic Trainer’s cell phone or Carroll Courts lobby phone
     - Location – corner of 18th St. and Parker St.
     - Give information of situation to operator (airway, breathing, circulation, deformities, etc.)

3. **Team Control**
   - **Assistant Coach:**
   - Direct athletes away from injured player

4. **Crowd Control**
   - **Campus Safety:** Keep crowd off field
   - **Athletic Director:** Keep relatives off field, but aware of the situation

5. **Contact Parents**
   - **AD or Head Coach:** Larry Carpenter or Matthew Yelton or Paul Furey
     - In life threatening situation call parents (home numbers in medical kit)
     - In non-life-threatening situation let the athlete call home

6. **Contact Team Physician**
   - **Supervising Athletic Trainer:** Jeff Mullins or Kathleen Kerecman
     - Dr. DeWayne Knight 423-421-8881

7. **Direct Paramedics**
   - **Campus Safety:**
     - Stand off Cherry St. to flag down EMTs

8. **Hospital**
   - **GA/SAT and/or Parents:**
     - Call on duty ATC ASAP with medical status
     - Provide necessary medical insurance information (in medical kit)

*If no ambulance is needed: SAT/GA or parent to drive. Call on duty ATC ASAP*
EMERGENCY PLAN WHILE TRAVELING

Hotel Emergencies

- In the event of an emergency while at your hotel, please assist student-athlete to the best of your ability in the absence of medical staff. Notify medical staff immediately to assist in emergency if available.
- Inform front desk of your hotel that you have an emergency and you need EMS
- All coaches/ATC should have each student-athletes insurance information and emergency information with them during travel.
- If the hospital visit requires the student-athlete to stay longer than the trip was planned, a member of the coaching staff must stay with the student-athlete.
- Call the ATC/Head Coach in charge of that team, if not available, to tell them what happened and what is going to be done with the athlete. Also, contact the Director of Athletics (Larry Carpenter) to notify them of the situation. If AD cannot be reached, contact Assistant AD Andrea Hudson, or Compliance Director Paul Cretton.

Bus Travel Emergencies

- In the event of an accident involving bus transportation of the team, i.e. a wreck. Please assist the student-athletes to the best of your ability as long as it is safe to do so.
- Triage injured student-athletes, dealing with the most serious injuries first.
- Notify EMS through 911 and let them know what happened including types of injuries, how many injured, and what is currently being done for the injured.
- A member of the coaching or medical staff, if possible, must go to the hospital with injured, and stay with athlete until parents or guardians arrive.
- Coaches and medical staff should have each student-athletes insurance information and emergency information with them during travel.
- After EMS has been notified a member of staff should notify the Athletic Director Larry Carpenter immediately to notify him of the situation. The AD can then notify the appropriate people on campus, including media. If AD is unavailable, then the chain of contact will consist of the Assistant AD Andrea Hudson, or Compliance Director Paul Cretton.
LIGHTING SAFETY POLICY

Lightening is a dangerous phenomenon. Athletic teams that practice and compete outdoors are at risk when the weather is inclement. The Athletic Training staff has developed a lightning safety policy to minimize the risk of injury from a lightning strike to Lee University athletes, coaches, support staff and fans. To monitor lightning the Athletic Training Staff will utilize both the Flash-to-Bang Method and a portable weather radar device. They will also make use of weather.com by phone or Wi-Fi transmission. Our policy is in accordance with the 2012-2013 NCAA Sports Medicine Handbooks and the 2012 NATA Position Statement for Lightening Safety.

General Policy: A member of the Athletic Training Staff (certified or student staff) will monitor the weather and make the decision to notify the head coach or officials of dangerous situations and recommend the suspension of activity in the event of lightning. Exceptions will be made for any activity where an Athletic Training staff member is not in attendance, whereby the supervising coach will have the ability to suspend activity. The decision to suspend activity will be based on:

Two subsequent readings on the radar device (DTN weather radar) in the 8-20 mile range regardless of the presence of visible lightning. (This device is portable and will be in the possession of the athletic training staff member or supervising coach) and/or
Utilization of the Flash-to-Bang Method (Count the seconds from the time the lightning is sighted to when the clap of thunder is heard. Divide this number by five to obtain how far away, in miles, the lightning is occurring.) (2011-2012 NCAA Sports Medicine Handbook). If it reveals lightening to be within 6 miles (a 30 second count between the flash of lightning and the bang of thunder) activity is to be suspended and everyone should seek shelter immediately.

Prior To Competition: A member of the Athletic Training staff and/or Athletic Director will greet the officials, explain that we have a means to monitor the lightning, and offer to notify the officials during the game if there is imminent danger from the lightning. The Athletic Director and game officials will then decide whether to discontinue play.

Announcement Of Suspension Of Activity: Once it is determined that there is danger of a lightning strike, the Athletic Training staff member will notify the head coach and/or official and subsequently immediately remove all athletes, coaches, and support staff from the playing field or practice area/facility. PA announcement to fans

Evacuation Of The Playing Field: Immediately following the announcement of suspension of activity all athletes, coaches, officials and support personnel are to evacuate to the nearest enclosed grounded structure.

Outdoor Instructions: If no safe structure or location is within a reasonable distance, find a thick grove of small trees surrounded by taller trees, a dry ditch without water, or seek a flat area (do not chose an open area where you will be the highest object.) When there, crouch down wrapping your arms around your knees and lower your head to minimize contact with the ground and wait for the storm to pass. (2011-2012 NCAA Sports Medicine Handbook).

Remember: An automobile, golf cart, or open shelter are not ideal shelters, but will offer you some protection from a lightning strike. Do not touch any metal structures directly after a lightning strike.

At Lee University
Soccer Game Field Lee University
- **Athletes:** Evacuate to their locker room (in front of Squires Library)
- **Soccer visiting athletes:** Evacuate to the dormitories across the street from their bench (Livingston Hall East). This includes Athletic Training staff, coaches, and officials
- **Fans:** evacuate to Squires Library or their vehicles

**Soccer Practice Field**

- All: Evacuate to shelter at the Lee U Married Students Dormitory or vehicles

**Softball Practice/Game**

- **All athletes:** Evacuate to Lee Athletics GA House and announcers tower
- **Fans:** Evacuate to adjacent O’Bannon-Bowdle Dormitory/Hall or their vehicles

**Baseball Practice/Game**

- **Lee University athletes:** Evacuate to their locker room. This includes all Athletic Training Staff, coaches, and officials.
- **Baseball visiting athletes:** Evacuate to the refreshment booth building
- **Fans:** Evacuate to adjacent school building (Ocoee Middle School) or their vehicles

**Tennis Practice/Game**

- **All athletes, coaches and officials:** Evacuate to the DeVos Recreation Facility adjacent to the tennis courts and sand volleyball court.
- **Fans:** As needed remaining staff, fans may also overflow to the DeVos Recreation Facility across from the tennis complex or to their vehicles

**Cross Country Race or Practice:**

- Nearest suitable structure. (see above for outdoor instructions)

**Golf venues:**

- Nearest suitable structures. (see above for outdoor instructions)

**Away Events:** All Lee University athletic teams participating outdoors will travel with the DTN weather radar or other device. A member of the Lee University Athletic Training or coaching staff will notify the game officials before competition and explain that we have a means to monitor the lightning. We will offer to notify the officials during the game if there is imminent danger from the lightning. The Lee University athletic Training staff reserves the right to discontinue playing, in the event the game officials have not suspended play with knowledge of inclement weather.

**Evacuation Of The Stands:** During a competition, once the decision to suspend activity has been made, a representative of the athletic department will announce via the PA system:

Fans are advised to immediately seek shelter in the nearest enclosed, grounded shelter.
REMEMBER: An automobile, golf cart, or open-sided shelter may not protect you from a lightning strike so these are not adequate shelters.

Resumption of Activity: during practice, activity may resume under the following conditions. This decision will be based on:

- Thirty minutes AFTER the last lightning strike within an 6-20 mile range on the DTN weather radar
- Thirty minutes AFTER the last lightning strike within a 6 mile range using the Flash-to-Bang method. During a game situation the activity will resume once the Athletic director, Athletic Training staff member and officials have conferred and the above criteria have been met.

Other Lightning Safety Tips: (2012-2013 NCAA Sports Medicine Handbooks)

1. There should be no contact with metal objects (bleachers, fences, golf clubs, bats)
2. Avoid single or tall trees, tall objects and standing in a group.
3. If there is no other shelter you may seek refuge in a hardtop vehicle. It is not the rubber tires that protect from lightning; it is the hard top metal roof that dissipates the lightning around the vehicle. Roll up the windows. Do not touch the sides of the vehicle.
4. The existence of blue skies and/or absence of rain are not protection from lightning. Lightning can strike 10 miles from the rain shaft.
5. DO NOT LIE FLAT ON THE GROUND
6. Avoid using a land line telephone. Cell phones are a safe alternative if in a safe structure
7. Avoid standing water and open fields
8. If in a forest, seek shelter in a low area under a thick grove of small trees.
9. If you feel your skin tingling immediately crouch and grab your legs and tuck your head as described above to minimize your body’s surface area.
10. Persons who have been struck by lightning do not carry an electrical charge. Therefore, enact the EMS system and provide emergency care. CPR with and AED is what is most often required. If possible, move the victim to a safe location.
11. For additional information see National Lightning Safety Institute at www.lightningsafety.com

Directions For Using The DTN Radar & Lightning Detector

1. Prior to practice or competition, monitor weather forecast via the Internet or by calling local agencies for up to date information.
2. Check for any National Weather Service-issued thunderstorm “watches” and “warnings”.
3. Monitor the weather for the following: sudden decrease in temperature, increase in air movement, sudden increase in humidity, visible dark clouds (though these do not have to be present for a lightning strike to occur.
4. Communicate with officials and/or coach prior to activity about potential for bad weather and our monitoring system.
5. Locate the DTN Lightning/Storm Detector in an area removed from other electronic devices or machinery, which could cause a false triggering.
6. When lightning is within 20 miles, the game officials will be notified. If appropriate the tarp should be placed at that time.
7. Activity will be suspended when:
DTN weather radar or other portable device registers 2 strikes within 8-20 mile range
The Flash-to-Bang Method reveals lightning within a 6 mile range (30 second or less count between the flash of lightning and the bang of thunder.

8. Once you have determined that there is imminent danger of a lightning strike, communicate to the head coach and/or head official.
9. Evacuate the field and stands in an enclosed-grounded building. REMEMBER, a golf cart, automobile, or open shelter does not provide protection from a lightning strike. If there is no available shelter i.e. cross-country, each individual should seek an area that is flat and in the open. Crouch down wrapping your arms around your knees and remain in that position until the danger of lightning is passed.
10. Activity may be resumed only IF the danger of a lightning strike is no longer present and no lightning strikes have occurred within the 20 mile range in 30 minutes. This decision to resume activity is to be made by a member of the Athletic Training Staff, athletic Director or Head Official.

FLASH – to – BANG Lightning Detection Method

This method of lightning detection should be used in conjunction with the DTN or other radar system.
1. Prior to practice or competition, monitor weather forecast to include accessing local/internet weather agencies for up to date information
2. Watch for the flash of lightning
3. Begin to count (one thousand, two one thousand….)
4. Stop counting when you hear the bang of thunder
5. Take this number and divide by 5. This will give you an approximation of how far away the lightning is (5 seconds = 1 mile). EXAMPLE: You see a flash of lightning and you begin to count. You reach 45 before you hear the bang of thunder. 45/5 = 9. The lightning would be approximately 9 miles away. Using this method you would suspend activity with lightning at or within 6 miles.
6. Activity is resumed with the permission of a member of the Athletic Training Staff 30 minutes after the last lightning detected at or within 6 miles.

Script For Conversation With Official

Hello, my name is _____________. I am a member of the Lee University Athletic Training Staff. I would like to speak with you regarding our lightning safety procedures. On site we have a lightning detector which I will use to monitor lightning. In accordance to NCAA recommendations, lightning detected within 8-20 miles is considered to pose an imminent threat. Per Lee University’s lightning safety policy, when the lightning detector reveals 2 consecutive strikes within the 8-20 mile range OR the flash/bang method reveals lightning less than 6 miles we strongly recommend suspending activity until the danger of a lightning strike has passed. We have a communication system to inform all participants and any fans.
Chain of Action for Lightning Emergencies

Athletic Training Staff Member Monitors Weather

LIGHTNING STRIKE

Imminent Danger Detected

Signal to Players to suspend activity → PA Announcement to Fans

Evacuate Players, Coaches, Officials → Evacuate Fans and Support Staff

Athletic Training Staff Monitor Lightning

If safe resume activity → If danger remains cancel activity

Pa Announcement During Inclement Weather

May I have your attention? We have been notified of approaching inclement weather. Activity will cease until we have determined it is safe and the risk of lightning is diminished. We advise you to seek shelter in the following areas:

At Lee University

- Soccer Game Lee University athletes: Evacuate to their locker room (in front of Squires Library)
- Soccer visiting athletes: Evacuate to the dormitories across the street from their bench (Livingston Hall East). This includes Athletic Training staff, coaches, and officials.
- Soccer fans at the soccer game site should evacuate to Squires Library or their vehicles
- Soccer Practice: Evacuate to shelter at the Lee U Married Students Dormitory
- Softball Practice/Game all athletes: Evacuate to Lee Athletics GA House and announcers tower
- Softball fans at game site should evacuate to adjacent O'Bannon-Bowdle Dormitory/Hall
- Baseball Practice/Game Lee University athletes: Evacuate to their locker room. This includes all Athletic training staff, coaches, and officials.
- Baseball visiting athletes: Evacuate to the refreshment booth
- Baseball fans at baseball site should evacuate to adjacent school building (Ocoee Middle School) or their vehicles
- Tennis Practice/Games all athletes: Evacuate to the DeVos Recreation Facility. This includes all Athletic Training staff, coaches and officials. If needed remaining staff, visitors may overflow to the DeVos Recreation Facility across from the tennis complex.
- Cross Country Race or Practice: Nearest suitable structure. (see above for outdoor instructions)
- Golf venues: Nearest suitable structures as above see outdoor instructions)

Though protection from lightning is not guaranteed, you may seek shelter in an automobile.

Thank you for your cooperation.
COMPLIANCE STATEMENT FOR ALL ATHLETIC DEPARTMENT PERSONNEL

As a member of the Lee University Athletic Department, I attest that I have read, understand, and will adhere to the Lee University Athletic Department Lightning safety Policy.

Signature of Staff: ________________________________ Date: _____________
Witness: ________________________________ Date: _____________
Lightening is a dangerous phenomenon. Athletic teams that practice and compete outdoors are at risk when the weather is inclement. The Athletic Training staff has developed a lightning safety policy to minimize the risk of injury from a lightning strike to Lee University athletes, coaches, support staff and fans. To monitor lightning the Athletic Training Staff will utilize both the Flash-to-Bang Method and a portable weather radar device. They will also make use of weather.com by phone or Wi-Fi transmission. Our policy is in accordance with the 2012-2013 NCAA Sports Medicine Handbooks and the 2012 NATA Position Statement for Lightening Safety.

GENERAL POLICY: A member of the Athletic Training Staff (certified or student staff) will monitor the weather and make the decision to notify the head coach or officials of dangerous situations and recommend the suspension of activity in the event of lightning. Exceptions will be made for any activity where an Athletic Training staff member is not in attendance, whereby the supervising coach will have the ability to suspend activity. The decision to suspend activity will be based on:

- Two subsequent readings on the radar device (DTN weather radar) in the 8-20 mile range regardless of the presence of visible lightning. (This device is portable and will be in the possession of the athletic training staff member or supervising coach) and/or
- Utilization of the Flash-to-Bang Method (Count the seconds from the time the lightning is sighted to when the clap of thunder is heard. Divide this number by five to obtain how far away, in miles, the lightning is occurring.) (2011-2012 NCAA Sports Medicine Handbook). If it reveals lightning to be within 6 miles (a 30 second count between the flash of lightning and the bang of thunder) activity is to be suspended and everyone should seek shelter immediately.

PRIOR TO COMPETITION: A member of the Athletic Training staff and/or Athletic Director will greet the officials, explain that we have a means to monitor the lightning, and offer to notify the officials during the game if there is imminent danger from the lightning. The Athletic Director and game officials will then decide whether to discontinue play.

ANNOUNCEMENT OF SUSPENSION OF ACTIVITY: Once it is determined that there is danger of a lightning strike, the Athletic Training staff member will notify the head coach and/or official and subsequently immediately remove all athletes, coaches, and support staff from the playing field or practice area/facility. PA announcement to fans

EVACUATION OF THE PLAYING FIELD: Immediately following the announcement of suspension of activity all athletes, coaches, officials and support personnel are to evacuate to the nearest enclosed grounded structure.

OUTDOOR INSTRUCTIONS: If no safe structure or location is within a reasonable distance, find a thick grove of small trees surrounded by taller trees, a dry ditch without water, or seek a flat area (do not chose an open area where you will be the highest object.) When there, crouch down wrapping your arms around your knees and lower your head to minimize contact with the ground and wait for the storm to pass. (2011-2012 NCAA Sports Medicine Handbook).

REMEMBER: An automobile, golf cart, or open shelter are not ideal shelters, but will offer you some protection from a lightning strike. Do not touch any metal structures directly after a lightning strike.
At Lee University

- Soccer Game Field Lee University athletes: Evacuate to their locker room (in front of Squires Library)
  Soccer visiting athletes: Evacuate to the dormitories across the street from their bench (Livingston Hall East). This includes Athletic Training staff, coaches, and officials.
- Soccer fans at the soccer game site should evacuate to Squires Library or their vehicles
- Soccer Practice Field: Evacuate to shelter at the Lee U Married Students Dormitory or vehicles
- Softball Practice/Game all athletes: Evacuate to Lee Athletics GA House and announcers tower
- Softball fans at game site should evacuate to adjacent O’Bannon-Bowdle Dormitory/Hall or their vehicles
- Baseball Practice/Game Lee University athletes: Evacuate to their locker room. This includes all Athletic Training Staff, coaches, and officials.
- Baseball visiting athletes: Evacuate to the refreshment booth building
- Baseball fans at baseball site should evacuate to adjacent school building (Ocoee Middle School) or their vehicles
- Tennis Practice/Game all athletes, coaches and officials evacuate to the DeVos Recreation Facility adjacent to the tennis courts and sand volleyball court.
- Tennis fans: As needed remaining staff, fans may also overflow to the DeVos Recreation Facility across from the tennis complex or to their vehicles
- Cross Country Race or Practice: Nearest suitable structure. (see above for outdoor instructions)
- Golf venues: Nearest suitable structures as above see outdoor instructions

Away Events: All Lee University athletic teams participating outdoors will travel with the DTN weather radar or other device. A member of the Lee University Athletic Training or coaching staff will notify the game officials before competition and explain that we have a means to monitor the lightning. We will offer to notify the officials during the game if there is imminent danger from the lightning. The Lee University athletic Training staff reserves the right to discontinue playing, in the event the game officials have not suspended play with knowledge of inclement weather.

EVACUATION OF THE STANDS: During a competition, once the decision to suspend activity has been made, a representative of the athletic department will announce via the PA system:

1. Fans are advised to immediately seek shelter in the nearest enclosed, grounded shelter.  
   (Soccer-Squires Libraryvehicles, Softball-O’Bannon/Bowdle Hall/vehicles, Baseball-Ocoee Middle School/vehicles, Tennis-DeVos Recreation Facility/vehicles)
2. REMEMBER: An automobile, golf cart, or open-sided shelter may not protect you from a lightning strike so these are not adequate shelters.

RESUMPTION OF ACTIVITY: during practice, activity may resume under the following conditions. This decision will be based on:

- Thirty minutes AFTER the last lightning strike within an 6-20 mile range on the DTN weather radar
- Thirty minutes AFTER the last lightning strike within a 6 mile range using the Flash-to-Bang method. During a game situation the activity will resume once the Athletic director, Athletic Training staff member and officials have conferred and the above criteria have been met.

**OTHER LIGHTNING SAFETY TIPS:** *(2012-2013 NCAA Sports Medicine Handbooks)*

1. There should be no contact with metal objects (bleachers, fences, golf clubs, bats)
2. Avoid single or tall trees, tall objects and standing in a group.
3. If there is no other shelter you may seek refuge in a hardtop vehicle. It is not the rubber tires that protect from lightning; it is the hard top metal roof that dissipates the lightning around the vehicle. Roll up the windows. Do not touch the sides of the vehicle.
4. The existence of blue skies and/or absence of rain are not protection from lightning. Lightning can strike 10 miles from the rain shaft.
5. DONOT LE FLAT ON THE BROUND
6. Avoid using a land line telephone. Cell phones are a safe alternative if in a safe structure
7. Avoid standing water and open fields
8. If in a forest, seek shelter in a low area under a thick grove of small trees.
9. If you feel your skin tingling immediately crouch and grab your legs and tuck your head as described above to minimize your body’s surface area.
10. Persons who have been struck by lightning do not carry an electrical charge. Therefore, enact the EMS system and provide emergency care. CPR with and AED is what is most often required. If possible, move the victim to a safe location.
11. For additional information see National Lightning Safety Institute at [www.lightningsafety.com](http://www.lightningsafety.com)

**DIRECTIONS FOR USING THE DTN RADAR & LIGHTNING DETECTOR**

1. Prior to practice or competition, monitor weather forecast via the Internet or by calling local agencies for up to date information.
2. Check for any National Weather Service-issued thunderstorm “watches” and “warnings”.
3. Monitor the weather for the following: sudden decrease in temperature, increase in air movement, sudden increase in humidity, visible dark clouds (though these do not have to be present for a lightning strike to occur.
4. Communicate with officials and/or coach prior to activity about potential for bad weather and our monitoring system.
5. Locate the DTN Lightning/Storm Detector in an area removed from other electronic devices or machinery, which could cause a false triggering.
6. When lightning is within 20 miles, the game officials will be notified. If appropriate the tarp should be placed at that time.
7. Activity will be suspended when:
   o DTN weather radar or other portable device registers 2 strikes within 8-20 mile range
   o The Flash-to-Bang Method reveals lightning within a 6 mile range (30 second or less count between the flash of lightning and the bang of thunder.
8. Once you have determined that there is imminent danger of a lightning strike, communicate to the head coach and/or head official.
9. Evacuate the field and stands in an enclosed-grounded building. REMEMBER, a golf cart, automobile, or open shelter does not provide protection from a lightning strike. If there is no available shelter i.e. cross-country, each individual should seek an area that is flat and in the open. Crouch down wrapping your arms around your knees and remain in that position until the danger of lightning is passed.
10. Activity may be resumed only IF the danger of a lightning strike is no longer present and no lightning strikes have occurred within the 20 mile range in 30 minutes. This decision to resume activity is to be made by a member of the Athletic Training Staff, athletic Director or Head Official.

FLASH – to – BANG Lightning Detection Method

This method of lightning detection should be used in conjunction with the DTN or other radar system.

1. Prior to practice or competition, monitor weather forecast to include accessing local/internet weather agencies for up to date information
2. Watch for the flash of lightning
3. Begin to count (one thousand, two one thousand….)
4. Stop counting when you hear the bang of thunder
5. Take this number and divide by 5. This will give you an approximation of how far away the lightning is (5 seconds = 1 mile). EXAMPLE: You see a flash of lightning and you begin to count. You reach 45 before you hear the bang of thunder. 45/5 = 9. The lightning would be approximately 9 miles away. Using this method you would suspend activity with lightning at or within 6 miles.
6. Activity is resumed with the permission of a member of the Athletic Training Staff 30 minutes after the last lightning detected at or within 6 miles.

SCRIPT FOR CONVERSATION WITH OFFICIAL

Hello, my name is ______________. I am a member of the Lee University Athletic Training Staff. I would like to speak with you regarding our lightning safety procedures. On site we have a lightning detector which I will use to monitor lightning. In accordance to NCAA recommendations, lightning detected within 8-20 miles is considered to pose an imminent threat. Per Lee University’s lightning safety policy, when the lightning detector reveals 2 consecutive strikes within the 8-20 mile range OR the flash/bang method reveals lightning less than 6 miles we strongly recommend suspending activity until the danger of a lightning strike has passed. We have a communication system to inform all participants and any fans.
Chain of Action for Lightning Emergencies

Athletic Training Staff Member Monitors Weather

LIGHTNING STRIKE

Imminent Danger Detected

Signal to Players to suspend activity  PA Announcement to Fans  Appropriate shelter

Evacuate Players, Coaches, Officials,  Evacuate Fans and Support Staff

Athletic Training Staff Monitor Lightning

If safe resume activity  If danger remains cancel activity

PA ANNOUNCEMENT DURING INCLEMENT WEATHER

May I have your attention? We have been notified of approaching inclement weather. Activity will cease until we have determined it is safe and the risk of lightning is diminished. We advise you to seek shelter in the following areas:

At Lee University

- Soccer Game Lee University athletes: Evacuate to their locker room (in front of Squires Library)
  Soccer visiting athletes: Evacuate to the dormitories across the street from their bench (Livingston Hall East). This includes Athletic Training staff, coaches, and officials.
- Soccer fans at the soccer game site should evacuate to Squires Library or their vehicles
- Soccer Practice: Evacuate to shelter at the Lee U Married Students Dormitory
- Softball Practice/Game all athletes: Evacuate to Lee Athletics GA House and announcers tower
- Softball fans at game site should evacuate to adjacent O’Bannon-Bowdle Dormitory/Hall
- Baseball Practice/Game Lee University athletes: Evacuate to their locker room. This includes all Athletic training staff, coaches, and officials.
- Baseball visiting athletes: Evacuate to the refreshment booth
- Baseball fans at baseball site should evacuate to adjacent school building (Ocoee Middle School) or their vehicles
- Tennis Practice/Games all athletes: Evacuate to the DeVos Recreation Facility. This includes all Athletic Training staff, coaches and officials. If needed remaining staff, visitors may overflow to the DeVos Recreation Facility across from the tennis complex.
- Cross Country Race or Practice: Nearest suitable structure. (see above for outdoor instructions)
- Golf venues: Nearest suitable structures as above see outdoor instructions)

Though protection from lightning is not guaranteed, you may seek shelter in an automobile.

Thank you for your cooperation.
COMPLIANCE STATEMENT FOR ALL ATHLETIC DEPARTMENT PERSONNEL

As a member of the Lee University Athletic Department, I attest that I have read, understand, and will adhere to the Lee University Athletic Department Lightning safety Policy.

Signature of Staff: ___________________________________________ Date: __________

Witness: ___________________________________________ Date: __________
ASTHMA POLICY AND PROCEDURE

Asthma Introduction

Asthma is described as a reversible obstruction, or a temporary blockage or inflammation of the bronchial airways. Although the exact causes of asthma are unknown, several factors, including exercise, may induce an attack. An episode of asthma may exhibit difficulty in the exhalation of the lungs typically due to allergic reactions from pollution, climate, and air particles. The majority of patients will have exercised-induced bronchospasm (EIB) which usually occurs during or minutes after vigorous activity and reaches its peak 5 - 10 minutes post-activity. It typically resolves in another 20 – 30 minutes.

Asthmatic Assessment:

History:
- Current Symptoms
  - Cough, wheezing, sputum production, shortness of breath, chest tightness
- Symptom Pattern
  - Perennial or Seasonal
  - Continuous or Episodic
  - Onset, Duration, Frequency
  - Diurnal Variation, Nocturnal Symptoms
  - Relation to Exercise
- Triggers
  - Viral Respiratory Infections
  - Exposure to known allergens (e.g. pollen, dust mites, animal dander)
  - Exposure to Irritants (e.g. cigarette smoke, perfume)
  - Medications (aspirin, beta-blockers)
  - Foods
  - Changes in Weather
  - Exercise
- Present Management
  - Current Medications
  - Response to Medications
- Disease Development
  - Age at onset, age at diagnosis
  - Past frequency of symptoms, exacerbations
  - History of hospital visits and admissions
  - Previous treatment and response
- Disease Impact
  - Time away from school or work
  - Effect of work, school, play
  - Limitation of physical activity
  - Associated Disorders (allergic rhinitis, sinusitis, nasal polyps, eczema)

Physical Examination

- Pulmonary Function Testing
  - Protocol consists of 5 to 8 minutes of steady-state exercise at high intensity (75% to 80% of maximum predicted heart rate.)
Spirometry measurements are taken every 3 minutes post-exercise (2,5,8,11,14,17,20)
  - Forced Expiratory Volume in 1 Second (FEV1)
  - A 15% decrease in FEV1 is considered a positive test.
  - Mild EIA = 15% - 20% drop in FEV1
  - Moderate EIA = 20% - 30% drop in FEV1
  - Severe EIA = 30+% drop in FEV1

Asthma Medications

Depending on the severity of asthma, medication can be taken on an as-needed basis (prn) or regularly to prevent or decrease breathing difficulty. Most of the medications fall into two major groups: quick relief medications and long-term control medications.

Quick relief medications are used to treat asthma symptoms or an asthma episode. The most common quick relief medications are the short-acting beta-agonists that relieve asthma symptoms by relaxing the smooth muscles around the airways. Common beta-agonists include Proventil and Ventolin (albuterol), Maxair (pirbuterol), and Alupent (metaproterenol). Atrovent (ipratropium), and anticholinergic, is a quick relief medication that opens the airways by blocking reflexes through nerves that control the smooth muscle around the airways. Steroid pills and syrups, such as Deltasone and mucus production in the airways; however, these medications take 48-72 hours to take effect.

Long-term control medications are used daily to maintain control of asthma and prevent asthma symptoms. Intal (cromolyn sodium) and Tilade (nedocromil) are long-term control medications, which help prevent swelling in the airways. Inhaled steroids are also long-term control medications. In addition to preventing swelling, they also reduce swelling inside the airways and may decrease mucus production. Common inhaled steroids include Vanceril, Vanceril DS, Beclovent and Beclovent DS (beclomethasone), Asmacort (triamcinolone), Aerobid (flunisolide), Flovent (fluticasone) and Pulmicort (budesonide). Leukotriene modifiers are new long-term control medications. They may reduce swelling inside the airways and relax smooth muscles around the airways. Common leukotriene modifiers include Accolate (zafirlukast), Ayflo (zileuton) and Singulair (mueltkast). Another long-term control medication, Theophylline, relaxes the smooth muscle around the airways. Common theophyllines in oral form include Theo-Dur, Slo-Bid, Uniphyl and UniDur. Serevent (salmeterol), in inhaler form, is also a long-term control medication. As a long-acting beta-antagonist, it opens the airways in the lungs by relaxing smooth muscle around the airways.

Inhaled medications are delivered directly to the airways, which is useful for lung disease. Aerosol devices for inhaled medications may include the metered-dose inhaler (MDI), MDI with spacer, breath activated MDI, dry powder inhaler or nebulizer. The most commonly used inhaled medications are delivered by the MDI, with or without the spacer. There are few side-effects because the medicine goes right to the lungs and not to other parts of the body.

It is critical that the patient use the prescribed MDI correctly to get the full dosage and benefit from the medication. Unless the inhaler is used in the right manner much of the medicine may end up on the patient's tongue, the back of their throat, or in the air. Use of a spacer or holding chamber helps significantly with this problem and their use is strongly recommended. A spacer is a device that attaches to a MDI and holds the medication in its chamber long enough for the patient to inhale it in
one or two slow deep breaths. This eliminates the possibility of inadequate medicine delivery from poor patient techniques.

**Equipment:**

- **Using the Metered Dose Inhaler (MDI):**
  The Lee University sports medicine staff may assist a student-athlete in the use of a prescribed MDI as follows:
  - Remove the cap and hold the inhaler upright
  - Shake the inhaler
  - Tilt head back slightly and breathe out
  - Hold the inhaler 1-2” away from mouth
  - If spacer is available, place directly in mouth (Note: Spacers are useful for all patients and especially helpful for young children and older adults as well as when using inhaled steroid medicines)
  - Press down on the inhaler to release the medicine as you begin to breathe in slowly
  - Breathe in slowly for 3 to 5 seconds
  - Hold your breath for 10 seconds to allow medicine to go deeply into lungs
  - Repeat puffs as directed. Wait one minute between puffs to allow the second puff to get into the lungs
    - Information provided by the American Academy of Family Physicians

- **Using a Peak Flow Meter:**
  1. Before each use, make sure the sliding marker or arrow on the Peak Flow Meter is at the bottom of the numbered scale (zero or the lowest number on the scale).
  2. Stand up straight. Take a deep breath. Place the mouthpiece of the Peak Flow Meter into mouth, securing lips tightly around the mouthpiece, keeping the tongue away. In one breath blow out as hard and as quickly as possible. Fast hard breath vs. a slowly blowing breath until emptying out all of the air from your lungs.
  3. Note the number on the scale and repeat the routine three times. (Note: if done correctly the numbers should be close together.) Record the highest and not the average.
  4. Suggested measurements are to take a reading between 7:00AM – 9:00AM and between 6:00PM – 8:00PM. Record measures twice daily. Chart reading.

**Basic Life Support Treatment for Severe Asthma:**

Patients who have progressed to severe asthma experience a combination of the following: shortness of breath (>30 respirations/min.), mental status changes (anxious, confused, combative, and drowsy), inability to speak in sentences, sweaty and unable to lie down. If the patient is not responding to or is unable to properly use their MDI, the sports medicine staff should:

- Call for EMS
- Maintain a patient airway
- Suction any secretions
- Administer oxygen therapy at 15 liters/minute with non-rebreather device
- Be prepared to assist ventilation with positive pressure ventilation with bag-valve-mask
- Administer epinephrine by a prescribed auto-injector
• Initiate early emergency transport

Procedures for Training and Testing in Use of MDI and BLS

Personnel must complete a training session each year with review of signs and symptoms of asthma and instruction in the proper use of MDI with and without a spacer.

Approved by: ____________________________, Medical Director    Date:_________
Asthma Protocol

Step 1. Assessing Asthma Severity
- PEF < 80% of best or predicted (on 2 successive days) or lack of response to β2-agonist*
- Coughing, breathlessness, wheeze, chest tightness, use of accessory muscles for breathing

Step 2. Initial Treatment
- Inhale a rapid-acting β2-agonist, up to 3 treatments in 1 hour

Mild Episode (if response is good)
- If PEF > 80% predicted or best
- Response to β2-agonist sustained for 4 hours:
  May continue β2-agonist every 3-4 hours for 24-48 hours

Moderate Episode (if response is incomplete)
- If PEF 60-80% predicted or best:
  - Add oral corticosteroid
  - Add inhaled anticholinergic
  - Continue β2-agonist

Severe Episode (if response is poor)
- If PEF < 60% predicted or best:
  - Add oral corticosteroid
  - Repeat β2-agonist immediately
  - Add inhaled anticholinergic

Contact asthma clinician for follow-up care
Contact asthma clinician for follow-up care
Immediately transport to hospital emergency department
EPI-PEN POLICY AND PROCEDURE

Epinephrine Auto-Injector Introduction

Epinephrine is the drug of choice for the emergency treatment of severe allergic reactions to insect stings or bites, foods, drugs or other allergens and for basic life support treatment for severe asthma. Epinephrine mimics the responses of the sympathetic nervous system. It quickly constricts blood vessels to improve blood pressure, reduces the leakage from the blood vessels, relaxes smooth muscle in the bronchioles to improve breathing through Broncho dilation and alleviate the wheezing and dyspnea, stimulates the heartbeat, and works to reverse the swelling and hives. The drug takes effect within seconds, but the duration of its effectiveness is short (about 10-20 minutes).

The Lee University sports medicine staff utilizes the Epi-Pen Auto-Injector, a disposable delivery system for self-administration. The Epi-Pen has a spring activated needle that is designed to deliver a single precise dose (0.3 mg of 1:1000 solution) of epinephrine to adults when activated. The Epi-Pen Jr. has a spring activated needle that is designed to deliver a single precise dose (0.15 mg. of 1:1000 solution) of epinephrine to infants/children under 8 years old when activated. It may be necessary in very severe reactions to administer a second dose after five minutes if initial response is inadequate.

Emergency Care for Anaphylaxis and/or Severe Asthma with Epi-Pen

The sports medicine staff should:
- Call for EMS (if not on-site or in-route)
- Maintain a patent airway
- Suction any secretions
- Administer oxygen therapy at 15 liters/minute with non-rebreather device
- Be prepared to assist ventilation with positive pressure ventilation with bag-valve-mask
- Administer epinephrine by a prescribed auto-injector
- Initiate early emergency transport

Indications/Contraindications for Epinephrine Administration

Epinephrine should be administered if the patient exhibits signs and symptoms of a severe allergic reaction (anaphylaxis), including respiratory distress and/or shock (hypo perfusion) or severe asthma. Patients who have progressed to severe asthma experience a combination of the following: shortness of breath (>30 respirations/min.), mental status changes (anxious, confused, combative, and drowsy), inability to speak in sentences, sweaty and unable to lie down. There are no contraindications for the administration of epinephrine in a life-threatening allergic reaction or severe asthma; however, precautions should be taken with elderly patients or patients with heart disease or hypertension.

Administration of Epinephrine
- Check the Epi-Pen to ensure the medication has not expired, has not become discolored, and does not contain particulates or sediments.
- Prep skin site with alcohol
• Remove the gray safety cap from the auto-injector
• Place the tip of the auto-injector against the lateral aspect of the patient's thigh midway between the waist and knee
• Push the injector firmly against the thigh until the spring-loaded needle is deployed and the medication is injected (at least 10 seconds)
• Dispose of the auto-injector in a biohazard container designed for sharp objects. Be careful not to prick yourself since the needle will now be protruding from the end of the injector
• Record that epinephrine was administered, the dose, and the time of administration

Side Effects

The patient may complain of side effects following the administration of epinephrine. Possible side effects include increased heart rate, pale skin (pallor), dizziness, chest pain, headache, nausea, vomiting, excitability and anxiousness.

Reassessment

Following the administration of epinephrine, it is necessary to reassess the patient. Reassessment should include continued evaluation of airway, breathing and circulatory status. Decreasing mental status, decreasing blood pressure and increasing difficulty in breathing indicate the allergic reaction or severe asthma is worsening. If the condition is worsening, consider the following interventions: injection of second dose of epinephrine if second auto-injector is available, provide emergency care for shock, be prepared to administer positive pressure ventilation with supplemental oxygen if breathing becomes inadequate, and be prepared to initiate CPR and apply AED if patient becomes pulseless.

If the patient's condition improves following administration of epinephrine, continue to perform ongoing assessments. Be aware patient may complain of side effects from the epinephrine. Conscious patients may also be administered 50 mg. diphenhydramine orally or sublingually for antihistamine effects. Continue oxygen therapy with a nonrebreather device and treat for shock if necessary.

*Any patient requiring epinephrine administration should be transported to the closest available medical facility for follow-up evaluation and treatment as soon as possible. Remember that epinephrine is short-acting (10-20 minutes) and signs and symptoms may return as drug wears off.*

Procedures for Training and Testing in Use of Epi-Pen Auto-Injector

Personnel should complete a training session each year with review of signs and symptoms and emergency medical care for allergic reaction, anaphylaxis, anaphylactic shock, and severe asthma. Personnel should complete a training session each year with instruction in the proper use and maintenance of the Epi-Pen and practice with the Epi-Pen Trainer.

Approved by: ________________________, Medical Director    Date:______
CONCUSSION MANAGEMENT GUIDELINES

1. Lee University (LU) will require student-athletes to sign a statement in which student-athletes accept the responsibility for reporting their injuries and illnesses to the sports medicine staff, including signs and symptoms of concussions. During the review and signing process student-athletes will watch a NCAA video on concussions and be provided with educational material on concussions.

2. LU will have on file and annually update an emergency action plan for each athletics venue to respond to student-athlete catastrophic injuries and illnesses, including but not limited to concussions, heat illness, spine injury, cardiac arrest, respiratory distress (e.g. asthma), and sickle cell trait collapses. All athletics healthcare providers and coaches shall review and practice the plan annually. These sessions will be conducted prior to the start of the sport season. Staff will sign up with Jeff Mullins, ATC, Head Athletic Trainer. The LU compliance office will maintain a list of staff that has completed the requirements on file.

3. LU sports medicine staff members shall be empowered to determine management and return-to-play of any ill or injured student athlete, as he or she deems appropriate. Conflicts or concerns will be forwarded to Jeff Mullins, Head ATC and DeWayne Knight, MD, ATC (head team physician) for remediation.

4. LU shall have on file a written team physician-directed concussion management plan that specifically outlines the roles of athletics healthcare staff (e.g., physician, certified athletic trainer, nurse practitioner, physician assistant, neuropsychologist). In addition, the following components have been specifically identified for the collegiate environment:
   a. LU coaches will receive a copy of the concussion management plan, a fact sheet on concussions in sport, and view a video on concussions annually. The LU compliance office will maintain a list of staff that has completed the requirement on file.
   b. LU sports medicine staff members and other athletics healthcare providers will practice within the standards as established for their professional practice (e.g., team physician, certified athletic trainer, physical therapist, nurse practitioner, physician assistant, neurologist, neuropsychologist)
   c. LU shall record a baseline assessment for each student-athlete in the sports of baseball, basketball, cheerleading, soccer, and softball, at a minimum. In addition, a baseline assessment will be recorded for student-athletes with a known history of concussion. The same baseline assessment tools should be used post-injury at appropriate time intervals. The baseline assessment should consist of the use of: 1) symptoms checklist, 2) standardized balance assessment (SAC-2) and 3) neuropsychological testing (computerized IMPACT test). Neuropsychological testing has been shown to be effective in the evaluation and management of concussion. The neuropsychological testing program should be performed in consultation with a neuropsychologist. Neuropsychological testing has proven to be an effective tool in assessing neurocognitive changes following concussion and can serve as an important component of an institution’s concussion management plan. However, neuropsychological tests should not be used as a standalone measure to diagnose the
presence or absence of a concussion as LU uses a comprehensive assessment by its
sports medicine staff.

d. When a student-athlete shows any signs, symptoms, or behaviors consistent with a
concussion, the athlete will be removed from practice or competition, by either a
member of the coaching staff or sports medicine staff. If removed by a coaching staff
member, the coach will refer the student-athlete for evaluation by a member of the
sports medicine staff. During competitions, on the field of play injuries will be under
the purview of the official and playing rules of the sports. LU staff will follow such
rules and attend to medical situations as they arise. Visiting sport team members
evaluated by LU sports medicine staff will be managed in the same manner as LU
student-athletes.

e. A student-athlete diagnosed with a concussion will be withheld from the competition
or practice and not return to activity for the remainder of that day. Student-athletes
that sustain a concussion outside of their sport will be managed in the same manner as
those sustained during sport activity.

f. The student-athlete will receive serial monitoring for deterioration. Athletes will be
provided with written home instructions upon discharge; preferably with a roommate,
guardian, or someone that can follow the instructions.

g. The student-athlete will be monitored for recurrence of symptoms both from physical
exertion and also mental exertion, such as reading, phone texting, computer games,
watching film, athletic meetings, working on a computer, classroom work, or taking a
test. Academic advisors and professors will be notified of student-athlete’s concussion,
with permission for release of information from the student-athlete.

h. The student-athlete will be evaluated by a team physician as outlined within the
concussion management plan. Once asymptomatic and post-exertion assessments are
within normal baseline limits, return to play shall follow a medically supervised
stepwise process.

i. Final authority for Return-to-Play\textsuperscript{13} shall reside with the team physician or the
physician’s designee as noted in the concussion management flowchart.

5. LU will document the incident, evaluation, continued management, and clearance of the
student-athlete with a concussion. Aggregate concussion numbers per sport will be reported
to the Director of Athletics annually.

6. Athletics staff, student-athletes and officials will continue to emphasize that purposeful or
flagrant head or neck contact in any sport should not be permitted.

\textbf{Approved by:}________________________ Medical Director \hspace{2cm} Date: ___________

\textbf{C. DeWayne Knight, M.D., ATC}

\textbf{Approved by:}________________________ Spinal Orthopedist \hspace{2cm} Date: ___________

\textbf{James Ozborne, M.D.}

\textbf{Approved by:}________________________ Dir. Sports Medicine \hspace{2cm} Date: ___________
Jeff Mullins, Head ATC

Approved by: ________________________ Ath. Tr. Curriculum Dir. Date: ____________

Kelly Lumpkin, PhD, ATC

Approved by: _______________________ Neuropsychologist Date: ____________

Robert Catanese, PhD

Reference Documents

1. NCAA and CDC Educational Material on Concussion in Sport. Available online at www.ncaa.org/health-safety


Lee University Athletic Training and Sports Medicine

Concussion Awareness Letter

The Lee University Athletic /Academic Counseling Departments would like to inform you that ______________ sustained a concussion on __________, ____, 20__. He/she was evaluated by C. DeWayne Knight, MD, team physician. __________ will undergo additional concussion testing today. A concussion or mild traumatic brain injury can cause a variety of physical, cognitive, and emotional symptoms. Concussions range in significance from minor to major, but they all share one common factor in that they temporarily interfere with the way your brain works. We would like to inform you that during the next few weeks this athlete may experience one or more of these signs and symptoms.

<table>
<thead>
<tr>
<th>Headache</th>
<th>Nausea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance Problems</td>
<td>Dizziness</td>
</tr>
<tr>
<td>Dioploia-Double Vision</td>
<td>Confusion</td>
</tr>
<tr>
<td>Photophobia- Light Sensitivity</td>
<td>Difficulty Sleeping</td>
</tr>
<tr>
<td>Misophonia- Noise Sensitivity</td>
<td>Blurred Vision</td>
</tr>
<tr>
<td>Feeling Sluggish or Groggy</td>
<td>Memory Problems</td>
</tr>
<tr>
<td>Difficulty Concentrating</td>
<td></td>
</tr>
</tbody>
</table>

As a department, we wanted to make you aware of this injury and the related symptoms that the student athlete may experience. Although the student is attending class, please be aware that the side effects of the concussion may adversely impact his/her academic performance. Any consideration you may provide academically during this time would be greatly appreciated. We will continue to monitor the progress of this athlete and anticipate a full recovery. Should you have any questions or require further information, please do not hesitate to contact us.

Thank you in advance for your time and understanding with this circumstance.

Jeff Mullins, ATC
Head Athletic Trainer
(423) 614-8462
jmullins@leeuniversity.edu
Lee University Athletic Training and Sports Medicine

Concussion Information: Home Instruction Sheet

Name_________________________________ Date: ________________________

You have had a head injury or concussion and need to be watched closely for the next 24-48 hours.

<table>
<thead>
<tr>
<th>It is OK to:</th>
<th>There is no need to:</th>
<th>DO NOT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use Tylenol (acetaminophen)</td>
<td>Check eyes with light</td>
<td>Drink Alcohol</td>
</tr>
<tr>
<td>Use an ice pack to head/neck for</td>
<td>Wake up every hour</td>
<td>Eat spicy foods</td>
</tr>
<tr>
<td>comfort</td>
<td>Stay in bed</td>
<td>Drive a car</td>
</tr>
<tr>
<td>Eat a light meal</td>
<td></td>
<td>Use aspirin, Aleve, Advil or other</td>
</tr>
<tr>
<td>Go to sleep</td>
<td></td>
<td>NSAID products</td>
</tr>
</tbody>
</table>

Special Recommendations:_____________________________________________________________________________________

_____________________________________________________________________________________

WATCH FOR ANY OF THE FOLLOWING PROBLEMS:

<table>
<thead>
<tr>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worsening Headache</td>
</tr>
<tr>
<td>Vomiting</td>
</tr>
<tr>
<td>Decreased level of Consciousness</td>
</tr>
<tr>
<td>Dilated Pupils</td>
</tr>
<tr>
<td>Increased Confusion</td>
</tr>
<tr>
<td>Stumbling/loss of balance</td>
</tr>
<tr>
<td>Weakness in one arm/leg</td>
</tr>
<tr>
<td>Blurred Vision</td>
</tr>
<tr>
<td>Increased irritability</td>
</tr>
</tbody>
</table>

If any of these problems develop, call your athletic trainer or physician immediately.

Athletic Trainer __________________________ Phone ______________________

Physician __________________________ Phone ______________________

You need to be seen for a follow-up examination at __________AM/PM at: ______________

Recommendations provided to ___________________________________________________________

Recommendation provided by ____________________________________________________________
Lee University Concussion Management Plan

**Obtain Baseline Testing:** Symptom checklist, SCAT2, and IMPACT testing data obtained for athletes in high-risk sports for concussion (baseball, basketball, cheerleading, soccer, and softball) or with pertinent medical history of concussion.

**Concussion Identified and Assessed:** Physical examination and assessment of concussion symptoms by medical staff (athletic trainer, physician assistant and/or physician: if physician not immediately available, athlete should be referred to physician for evaluation within 24 hours of injury if possible if not emergent; if emergent, athlete should be transported to closest emergency department); athlete held from all physical activity; given concussion information home instruction sheet; notify parent/guardian of concussion; Athlete repeats baseline testing with Symptoms checklist, and IMPACT (within 24 hours of injury if possible).

**Concussion Management:** Athlete held from all physical activity; implement DHA Omega-3 supplementation (3 grams daily for 30 days or until asymptomatic if longer); re-assess athlete daily by medical staff; administer symptom checklist daily until completely asymptomatic; notify academic advisor (consideration of academic modifications/restrictions).

**Athlete Asymptomatic:** Athlete repeats baseline testing with symptoms checklist, SCAT-2, and IMPACT (unless directed otherwise by physician and/or

**Test Results Return to Baseline:** Perform exertional testing; re-evaluation by physician for return to play decision

**Test Results NOT Returned to Baseline:** When medically cleared by physician, repeat test battery; consider neuropsych consult with more detailed test battery.

When medically cleared by physician, repeat exertional testing; re-evaluation by physician for return to play decision
Exertional Testing Protocol Following Concussion

Symptom Checklist, SCAT2, and IMPACT testing WNL

Exertional Testing Protocol
1. 10 min on stationary bike; exercise intensity <70% maximum predicted heart rate
2. 10 min continuous jogging on treadmill; exercise intensity <70% maximum predicted heart rate
3. Strength training: (i.e. push-ups, sit-ups, squat thrusts)
4. Advanced cardiovascular training: sprint activities
5. Advanced strength training: weight lifting exercises
6. Sport specific agility drills (no risk of contact)

If no change or increase in symptoms, move to next step.

Non-contact practice following completion of exertional protocol
If no change or increase in symptoms, move to next step.

Limited to full contact practice
If no change or increase in symptoms, final return to play decision made by medical staff.
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FIRE PREVENTION

It is essential that we at this facility have a well-coordinated plan in case of a fire or other extreme emergencies.

What is Included?

Administration

- Make a list of the major workplace fire hazards and their proper handling and storage procedures.
- Make a list of potential ignition sources, such as welding and smoking, and the type of fire fighting equipment used to extinguish such fires.
- Make a list of the facility personnel responsible for equipment and system maintenance used in fire prevention and emergency incidents.
- Make a list of the facility personnel responsible for control of fuel source hazards (such as oxygen).
- Make quarterly inspections of the facility to eliminate and control accumulations of flammable and combustible waste materials.
- Regularly test all alarms and public address systems to see if they are operating properly and can be heard in all areas of your facility.
- Inspect fire doors and emergency exits to ensure that they are passable.
- Post evacuation plan diagrams throughout your facility.
- Place emergency phone numbers where all employees can see them.

Training

Every employee must be taught the fire hazards of the materials and processes to which they are exposed, covering those parts of the Fire Prevention Plan, which they need to know in the event of an emergency.

Every employee must be taught to use fire extinguishers or hose outlets and operate manual pull alarms.

The written plan must be kept in the workplace and made available for employee review.

It must be noted that an employee is not obligated to use a fire extinguisher or hose and that only those who have been trained to use them may choose to use them if they deem the situation is safe enough to do so.
Equipment and Potential Hazards and How to Handle Them

The employers must check and maintain safety controls on furnaces and other heat-producing equipment, fire extinguishers, sprinklers, smoke alarm systems and other fire prevention devices. These fire prevention maintenance procedures must be included in the written fire prevention plan.

The first aspect of such a program is obviously actions taken to prevent one. Though not much can be done to prevent an earthquake, there are things that can be done to minimize the damages caused by one. Thus, a few things should be followed closely with these disasters.

1) Always ensure that your work area is clean. If large stacks of paper, catalogs, files, and other combustible materials are allowed to build up near possible sources of ignition, such as electrical sources, they could pose a serious fire hazard.

2) Always make sure that any flammable or combustible materials, cleaning and paper products, for example, are kept several feet away from heat sources, such as coffee makers, space heaters, and office equipment and machinery.

3) If you ever need to work with cleaning solutions or other liquids that are flammable, ensure that they are stored in the proper containers and kept in well-ventilated areas that are well away from any heat source. And again, when you need to work with these liquids, ensure that you're wearing the proper protective clothing, such as gloves and a smock. (NOTE: If you have any questions about the proper handling of flammable liquids, again, read all labels, read Material Safety Data Sheets (MSDSs) provided by the products' manufacturers, ask your supervisor if you don't know where the MSDSs are kept, and speak to him or her about any precautions you should take).

4) If the owner/doctor requires that employees refrain from smoking in certain, or all, areas of the office, always obey this policy.

5) If you're allowed to smoke at this facility, always put cigarettes out in an ashtray. And never empty an ashtray into a wastebasket or garbage can until you're absolutely sure that all cigarettes and matches in the ashtray are extinguished.

6) If you spot a potential fire hazard that you can't correct easily and safely yourself, immediately report the problem to the safety coordinator. Also report any fire or other safety hazard you have been able to correct so that he or she will be aware of the situation.

7) Make sure that you know the location of all the fire extinguishers and alarms in your office. And ensure that you remember the steps you're supposed to take to set off an
alarm and to use a fire extinguisher, if you’ve been trained to use this equipment. Don’t wait until a fire occurs. If you’re unclear about any steps or procedures you need to follow, check with the safety coordinator now.

8) Never block your office fire exits, extinguishers, sprinklers, and alarms. If you and your fellow employees can’t make your way through a fire exit or reach or find an extinguisher or alarm during a fire, the result can obviously be disastrous. And if part of your office’s sprinkler system is blocked, it may be rendered ineffective. If you notice that any of these areas are blocked, report the problem immediately to the safety coordinator.

9) Understand the steps you’re supposed to take to report a fire. Ask the safety coordinator if you have any questions about the procedure you need to follow.

10) Beware of flammable liquids such as alcohol, petroleum distillates, methyl methacrylate, etc. are a common fire hazard that from time to time may be found in this facility. The single most important concern is that vapors become flammable when they mix with air and come into contact with an ignition source. Flammable vapors spread quickly. Also, mixing incompatible chemicals may cause a fire or an explosion or be toxic when inhaled. Make sure there is adequate ventilation, and that they are stored in tight metal containers away from ignition sources. They should not be near heat or fire sources. You should clean up spills immediately and remove any clothing that has absorbed a flammable liquid.

11) Know your office’s evacuation procedures. Know which exit you’re supposed to use. You’re supposed to meet with others in your department. Again, if you have any questions, ask the safety coordinator.

12) All heavy items and objects on desks and tables and wall cabinets should be well secured on it so as not to “walk” and fall in case of a quake. Tables and chairs themselves should not have weak or broken legs and parts. No one should be stationed sitting under something heavy which could fall on his/her head in case of an earth quake; if you are, notify the safety coordinator immediately so the situation is corrected ASAP.

13) Oxygen tanks should be securely fastened to a stand AT ALL TIMES. Here you are dealing with something like a bomb. If it falls it may explode just like a bomb.

14) 14) It is always easier and safer to stow things under a table, or in a storage area other than your work area.

15) Fire extinguisher, smoke detectors, sprinkler systems, in-house alarm systems, etc., should be periodically checked to make sure that they are in operation and will not malfunction in an emergency situation. These actions are generally done by outside
vendors or contractors, or those who initially installed the systems, so we don’t have to worry about doing anything ourselves, other than making sure it gets done.

16) Stockrooms and/or Vault Areas should be maintained in an uncluttered condition.

In an effort to prevent fires from occurring, the following should be observed:

17) Do not block aisles and/or exits.

18) Maintain supplies/files in a neat and orderly manner. Periodically inspect areas for fire safety.

19) In an area, which is protected by a sprinkler system - Do not store materials any closer than 18 inches from the sprinkler heads.

20) Do not smoke in storage areas.

21) Smoking is not permitted at any site.

However, the following are some general rules:

22) Observe NO SMOKING signs where posted. Remember... cigarettes that were accidentally forgotten cause most fires.

23) If you, your colleagues or guests are smokers, be sure to provide plenty of safety ashtrays, which automatically extinguish a cigarette, if it burns too close to the edge. Do not leave a cigarette unattended in an ashtray where it may fall out. Scorched surfaces show how hazardous it can be to lay cigarettes on the edge of shelves, counters, or tables.

24) While we should never empty ashtrays into a wastebasket, if neatness demands it, be sure that the ashes are completely cold before emptying.

25) Overloaded electrical outlets cause many building fires. Do not create an "octopus" by inserting a series of 2-way or 3-way plugs into the same outlet. Connect only one cord to each receptacle socket. Use of extension cords is prohibited. If you are in need of additional outlets, contact your supervisor.

26) When plugging or unplugging electrical equipment, be sure it is turned off, avoid touching metal or standing on a wet surface when doing so. Remember, for your safety, unplug electrical equipment by holding the plug itself while removing it from the socket. Do not unplug it by pulling on the cord.
FIRE DRILL

In case of a serious emergency such as fire or serious earthquake, or other disasters, the following are the steps to be taken to ensure maximum safety for all staff and patients:

1. Remain calm.
2. Set off the alarm and announce over the internal office intercom that there is a fire, etc., in the building, stating the exact location of the emergency.
3. Call the fire department. The telephone number is placed in a place for all employees to see. If not available, call emergency, 911. The person in charge of calling the fire department is the Office Manager.
4. The backup person in charge of calling the fire department is ____________ staff member _________.
5. Do not use the elevator.
6. If there is smoke in the corridor, look for your alternate escape route. If you must escape through the smoke, stay as low as possible. Get down and crawl to the exit. By staying low, you can breathe the cleaner air near the floor.
7. Be aware of all the exits of the building.
8. Everyone is to take the shortest route outside the building through one of these exits.
9. We all meet at Schimmel Park ____________.
10. Charge nurse ________ is responsible for a head count of all the employees. If you know somebody is missing or possibly trapped, notify this person immediately.
11. The owner/doctor is then responsible to attend the victims and deliver any help they can.
12. The owner/doctor is then responsible to make sure all the patients are safe.
Other suggestions to remember:

1. Do not panic; keep calm. This is the most important.
2. Smoke is lighter than air and travels in higher altitudes. If you run against too much smoke, continue progress by crawling.
3. In case of earthquake or other physically destroying catastrophes, get under sturdy objects, like desks or door frames.
4. If you are trapped in a room and you are near a bathroom, make sure you try to restrict the fire from infiltrating by clogging the openings around the door.
5. Feel closed doors. If it appears very hot do not open the door.
6. If you become trapped – call the fire department and building manager for assistance.
7. If possible, seek refuge in an office/room. Stuff cracks around the door with whatever cloth you can find. Even clothing. If possible, wet the cloth with whatever is available (from a flower vase, drinking fountain, or even a coffee pot).
8. If you are in a room with a window (which can be opened), open it slightly at the top and bottom. The space at the top will exhaust smoke and the space at the bottom will admit outside air.
9. If the room starts to fill up with smoke and there are no windows which can be opened, wait until you absolutely must (to stay conscious) to break a window. Once a window is broken it can no longer prevent smoke and gases from entering the room from the outside.
10. If your clothes catch fire. Stop...drop to the ground...and roll.
FIRE EXTINGUISHERS

You should never attempt to fight even a small office fire until people have been evacuated from the area and the fire department has been called.

Do not fight the fire if you are unsure about the type of extinguisher or how to use it, or if the fire is spreading or blocking your escape.

Normally, the fire extinguisher will be the first defense against a fire (in an occupied area) and it has maximum effectiveness when used during the early stages of fire by properly trained individuals. Call your local fire department for fire extinguisher training.

Fire extinguishers are provided to attack a fire in the period between discovery and the arrival of trained fire department personnel.

Fire extinguishers were designed to permit the discharge of a contained amount of fire extinguishing agent at the will of a human operator.

The extinguisher must fit the fire. There are different types to fit different materials:

A Type - Ordinary combustibles/wood, cloth, paper, rubber, many plastics and other ordinary materials that burn easily.

B Type - Flammable liquids/gasoline, oil, grease, tar, oil-based paint, lacquer, and flammable gas.

C Type - Electrical equipment/energized electrical equipment, wiring, fuse boxes, circuit breakers, machinery, and appliances.

Operating instructions can usually be found on the fire extinguisher. These instructions will enable you to put it in service with minimum delay. However, familiarizing yourself with the proper operation of the equipment (and its limitations) prior to having to use it, could save lives and property.

As per operating procedures, all fire extinguishers are to be inspected annually to ensure their effectiveness should a fire occur. This function is coordinated through the Purchasing Department. However, in high-rise buildings, the Building Engineer will be responsible for maintenance.

Each extinguisher should be mounted in a position, which is easily accessible and visible. If an extinguisher is mounted behind closed doors (i.e., Janitor's Rooms, Stockrooms, etc.), a sticker
indicating its presence should be placed on the exterior of the door.

Extinguishers should be placed to ensure that no person would have to travel more than seventy-five (75) feet to have access to it.

Method of Operation

All employees should learn how to use them in case it is necessary.

Knowledge of the types of extinguishers does not ensure maximum effective usage. The same extinguisher in the hands of different operators can provide widely different results on the same fire depending on the skills used in the application of the available quantity of extinguishing agent.

Selecting the proper extinguisher to fight a given fire is obviously going to affect the outcome. The wrong type of extinguisher may fail not only to extinguish the fire, but also may cause great personal hazard from electrical shock, poisonous fumes, spreading of fire, or explosion.

In order to operate an extinguisher properly, the operator must know:

- The correct position for operation
- How to remove any restraining or locking device
- How to activate (or start) agent discharge
- How to direct the extinguishing agent on the fire

The Correct Position for Operation

Most extinguishers deliver their entire quantity of extinguishing agent in a matter of seconds. There is no time for experimentation or using trial and error methods when a fire threatens destruction of life and property. Most extinguishers must be held in an upright position to achieve maximum effectiveness.

How to Remove Restraining and/or Locking Devices

Generally, the restraining and/or locking device found on an extinguisher is referred to as the “PIN.” This pin must be removed prior to squeezing the trigger or lever. Simply twist the pin as you pull it out. Do no squeezes the lever or trigger as you attempt to do this, or the pin will not come free.
How to Activate Agent Discharge

The extinguisher is activated by simply squeezing the lever or trigger together with the carrying handle.

How to Direct the Extinguishing Agent at the Fire

The nozzle or hose of the extinguisher should be directed first at the base of the flames. Next you should sweep the flames off the burning surface. This is accomplished by directing the discharge to the near edge of the fire, gradually progressing forward, moving the discharge from side to side. The application should be continued even after the flames appear to be extinguished (if agent quantities are adequate) to allow added time for cooling and to prevent, as far as possible, a reflash from adjacent hot surfaces or open flames.

Operators' Distance from Fire

Normal operation should be attempted from approximately five to seven feet from the fire (if possible). However, when dealing with flammable liquids, to prevent splashing, initial attacks should be made no closer than eight to ten feet.

NOTE: Prior to beginning the extinguishment process, the operator should locate an escape route. Should the extinguishment efforts fail and the fire begins to spread rapidly, the operator should know in advance where she/he intends to retreat to. In other words, stand with your back to an exit (wherever possible) before attempting to extinguish the fire. This way, if the fire suddenly gets out of control, you can get to an exit and move to safety.
FIRE HOSES

Hoses that may be located in hallways throughout your building are attached to high-volume high-pressure water pipes. These hoses provide an effective means of first aid fire fighting. However, hoses should not be used by anyone except those thoroughly trained in their operation. In an incident such as earthquake, where the Fire Department response will be delayed, common sense will prevail.

If you are not trapped and the fire is large enough to require the use of the hose...it is time for you to retreat!!! In this case, the fire should be left for trained fire department personnel to fight. Close all doors behind you and leave.

Important Reminder

The most important thing to remember when accessing the fire (prior to attempting to extinguish it) is never attempt to fight a fire if you are alone.

Method of Operation

In the event you become trapped and/or it is necessary for you to use this equipment, there are a few simple steps to remember:

1. The hoses must be completely out of the cabinet prior to turning on the water.
2. All of the kinks must be out of the hose prior to turning on the water.
3. Brace your feet! Place one foot behind the other prior to turning on the water.

NOTE: Whenever possible, it is recommended that at least two persons man the nozzle end of the hose.

The nozzle of the hose should be directed first at the base of the fire. Next you should sweep the flames off the burning surface. This is accomplished by directing the water to the near edge of the fire, gradually progressing forward, directing the stream of water from side to side.

NOTE: The application should be continued even after the flames appear to be extinguished to allow added time for cooling and to prevent re-ignition.
FIRE EMERGENCY ACTION PLAN

This facility has established Fire and Disaster Procedures in writing and how to escape the building for this or any other emergency. These procedures should be part of our new employee's orientation. A record should be kept which logs training of the staff and indicates understanding of the procedures. Written procedures should be given to each employee, and they should sign a permanent file copy indicating they have read and understand these procedures. This facility will make a practice of auditing the staff on fire and disaster procedures to assure compliance.

IN AREA OF FIRE

1. Remove person(s) in any immediate danger.
2. Close door to room of fire to confine it to the area where it started.
3. Activate nearest alarm clock.
4. Call 911. Give exact fire location, floor, area and room.
5. Follow the procedure for evacuation.

STAFF

1. Upon the announcement of "code red", evacuation procedures must begin.
2. Charge Nurse will supervise evacuation teams.
3. Charge Nurse will designate someone to meet the fireman at the front entrance.
4. Charge Nurse will see that all persons are safely evacuated and accounted for and that no one is injured.

These people can be contacted for more information or explanation of these duties under this plan

Remember

1. Remain Calm
2. Remove person(s) in immediate danger
3. Close door to fire area
4. Activate nearest alarm
5. Notify fire department and/or paramedic
EVACUATION

In case of fire or other emergency in this facility, all personnel shall evacuate the work area by the exits designated by arrows, exit signs or escape plan route maps. Act calmly.

Assigned Employee Responsibility
In event of an emergency evacuation, certain individuals have the responsibility to ensure that patients are evacuated from patient areas. These responsibilities have been previously stated under Fire Drill and would apply to all emergency situations.

A head count will be conducted and this person responsible will notify the fire authorities of any missing employees.

Rescue and Medical Duties
The responding fire/rescue service will be solely responsible for any and all rescue and medical duties. Employees are not expected to perform rescue and medical duties.

Reporting
Fire and other emergencies are reported to personnel in the facility using the alarm system for this practice. The alarm system is by voice.

For further information or explanation of this plan contact the safety coordinator.
EARTHQUAKE PROCEDURES

1. After trembling has stopped:
   a) The safety coordinator will supervise employees in the evacuation of patients and other personnel to the parking lot.
   b) Qualified trained personnel will administer first aid and CPR as needed.

2. At the safety meetings, a constant topic of discussion will be the assignment of office staff to fulfill certain duties in an emergency situation.

   These duties shall include but not be limited to:
   a) Communications – telephone responsible for appropriate emergency response.
   b) Emergency medical equipment.

The actual movement of the ground in an earthquake is seldom the direct cause of death or injury. Most causality result from falling objects and debris because the shocks can shake, damage, or demolish buildings and other structures. Earthquakes may also trigger landslides and generate huge ocean waves (seismic waves), each of which can cause great damage.

Injuries are commonly caused by:

1. Partial building collapses, such as toppling of chimneys, falling brick from wall facings and roof parapets, collapsing walls, falling ceiling plaster, light fixtures, and pictures.
2. Flying glass from broken windows.
3. Overturned bookcases, fixtures, and other furniture and appliances.
4. Fires from broken chimneys, broken gas lines, and similar causes. The danger may be aggravated by the lack of water due to broken water mains.
5. Fallen power lines.
6. Drastic human actions resulting from panic.

Before the Next Earthquake

Be prepared. Take the time NOW to read the following checklist and take the necessary actions to minimize risks to yourself and your office.
EMERGENCY SUPPLIES

Be sure you have these basic supplies on hand near your office in an accessible location:

1. Portable radio and extra batteries.
2. Flashlights and extra batteries.
3. First aid kit and handbook.
4. Bottled water in your desk drawer. Enough drinkable water for each employee for at least three days. Keep a canteen of water in the car too.
5. Food (canned foods, mechanical can opener, and powdered milk for at least one week’s meals).
6. Required medications, glasses.
7. Pipe or crescent wrenches to turn off gas and water supplies.
8. Small bottle of chlorine bleach to purify drinking water.
9. Blankets, warm clothes, and sturdy shoes.

Check work areas and other areas for earthquake hazards:

1. Brace or anchor high or top heavy shelves, machinery or other equipment which would fall during a tremor.
2. Bolt down or provide other strong support for water heaters and other gas appliances that could result from broken lines or connections.

If building is windowless, consider alternate means of ventilation and lighting if the power is off. Consider other possibilities should destruction occur (e.g., what if persons on upper floors cannot descend to the ground floor?). Plan assistance for physically handicapped employees. Designate areas in the building, which may be suitable, as shelter areas should employees be required to stay after the earthquake.

During an earthquake

1. If you are indoors, DUCK or drop down to the floor. Take cover under a sturdy desk, table or other furniture. HOLD on to it and be prepared to move with it. Hold the position until the ground stops shaking and it is safe to move. Stay clear of windows,
fireplaces and heavy furniture or appliances. Don't rush outside. Falling glass or
building parts may injure you. DO NOT try using the stairs or elevators while the
building is shaking or while there is danger of being hit by falling glass or debris.

2. If you are outside, get into the OPEN, away from buildings and power lines.

3. If you are driving - STOP if it is safe, but stay inside. DO NOT stop on or under a bridge,
overpass or tunnel. Move your car as far out of the normal traffic pattern as possible.
DO NOT stop under trees, light posts, electrical power lines or signs.

4. If you are in a mountainous area, be alert for falling rock and other debris that could be
loosened by the quake.

5. In a crowded public place, DO NOT rush for the exits. Stay calm and encourage others
to do so.

After the earthquake

1. Check for injuries:
   a. If a person is not breathing or is bleeding, seek medical assistance from a nurse
      or doctor.
   b. DO NOT attempt to move seriously injured persons UNLESS they are in
      immediate danger of further injury.
   c. Cover injured persons with blankets to keep them warm.
   d. Wear sturdy shoes and gloves to avoid injury from broken glass and debris.
   e. If damage is extensive, wear a dust mask, wet handkerchief, or other cover for
      the nose and mouth to reduce inhalation of dust.

2. Safety checks. Check for the following potential risks:
   a. Fire or fire hazards.
   b. Gas leaks. Shut off the main gas valve if a leak is suspected or identified by the
      odor of natural gas. Wait for the Gas Company to check it and turn it back on.
   c. Damaged electric wiring. Shut off power at the control box if there is any
      damage to your house wiring.
   d. Downed or damaged utility lines. DO NOT touch downed power lines or
      objects of any kind touching them.
   e. Fallen items in closets and cabinets. Beware of items tumbling off shelves
      when you open the door.
   f. Check that each telephone is on its receiver. Phones that are off-hook tie up
      the telephone network unnecessarily.
Clear Water          Cloudy Water
One Quart            One Quart
         - 2 drops           - 4 drops
One Gallon           One Gallon
           - 8 drops           - 16 drops
5 Gallons  - 1/2 teaspoon  5 Gallons - 1 teaspoon

3. Mix water and hypochlorite thoroughly before stirring or shaking in a container. Let stand for 30 minutes before using. A slight chlorine odor should be detectable in the water. If not, repeat the dosage and let stand for an additional 15 minutes.

Note: Bringing it to a rapid boil may also purify water. However, due to its chemical content, swimming pool or spa water should not be used as a primary source of drinking water.

Emergency calls only

After a disaster, especially earthquakes, there is usually a high volume of telephone calls. It is important you limit phone calls to emergencies only. Do not call 9-1-1 or the police for confirmation of an earthquake. Listen to your local radio or television station for information.

Blocking

In cases of extreme congestion of the telephone network, your local phone company and/or long distance carriers may institute blocking. Blocking prevents overloading the system by diverting some calls to recordings, allowing other calls to complete.

If you need to place an emergency call:

1. Make sure receivers of all extension phones are on the switch hook.
2. Stay on the line. You may not hear dial tone immediately; the delay could be as long as a minute or more.
3. Do not repeatedly depress the switch hook; this will further delay your call.
4. If you receive a "fast busy" or "all circuits are busy" recording, hang up and try again.
5. If physical damage occurs in our equipment or facilities or your wiring, it may not be possible to complete your call.
# DISASTER TRAUMA KIT

<table>
<thead>
<tr>
<th>QUANTITY</th>
<th>DESCRIPTION</th>
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</thead>
<tbody>
<tr>
<td>6</td>
<td>saline, normal sterile, 500cc</td>
</tr>
<tr>
<td>5</td>
<td>compress, multi trauma, sterile 10&quot; x 30&quot;</td>
</tr>
<tr>
<td>8</td>
<td>blanket, thermal rescue</td>
</tr>
<tr>
<td>1</td>
<td>bandage, triangular, 12/bag</td>
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<tr>
<td>12</td>
<td>bandage, kerlix sterile, 4 ½&quot; x 4 ½ yds.</td>
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<tr>
<td>1</td>
<td>gauze pads, 4&quot; x 4&quot;, 100 box</td>
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<tr>
<td>6</td>
<td>splint cardboard, 32&quot;</td>
</tr>
<tr>
<td>6</td>
<td>splint cardboard, 18&quot;</td>
</tr>
<tr>
<td>10</td>
<td>ice packs</td>
</tr>
<tr>
<td>12</td>
<td>light, cyclone</td>
</tr>
<tr>
<td>1</td>
<td>scissors, emergency</td>
</tr>
<tr>
<td>2</td>
<td>tape, 1&quot; x 10 yds., spool</td>
</tr>
<tr>
<td>2</td>
<td>tape, 2&quot; x 5 yds., 3 cut spool</td>
</tr>
<tr>
<td>1</td>
<td>antiseptic swabs, 150/box</td>
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<tr>
<td>1</td>
<td>burn towel dressing, 20&quot; x 30&quot;</td>
</tr>
<tr>
<td>1</td>
<td>burn towel dressing, 12&quot; x 20&quot;</td>
</tr>
<tr>
<td>1</td>
<td>burn mask dressing</td>
</tr>
<tr>
<td>1</td>
<td>disaster trauma kit, empty</td>
</tr>
</tbody>
</table>
EARTHQUAKE EMERGENCY ACTION PLAN

Preparation

- Before an earthquake hits, secure top-heavy objects to structural elements of the building.
- Remove heavy objects, liquids and chemicals from high shelves.
- Prepare at least one first aid kit for each designated safety area; check and maintain them quarterly.
- Provide a 72-hour supply of water. Have a transistor radio and batteries available.
- Have heavy utility gloves available.

Evacuation

- It is usually safer to remain in the building in case of an earthquake.
- Stay away from windows, bookcases, filing cabinets and any objects that may fall or shatter.
- Brace yourself in the core of the building. Protect your head.

After and Earthquake

- Check utilities for gas and water leaks, and electrical shorts.
- Look for injured persons and assist as possible.
- Open doors carefully; watch for falling objects.

For further information or explanation of this plan contact the safety coordinator.

This form should be copied and given to all employees upon completion of training.
TORNADO and HURRICANE PROCEDURES

Before a Tornado and Hurricane

1. Review the “Escape Plan” diagram to learn the route and location of the closest tornado shelter or hurricane evacuation area. It is posted in strategic locations throughout the facility.

2. When a tornado or hurricane warning is issued in which there is immediate danger, the following steps must be taken:
   - Each supervisor will instruct their personnel and any other in their work areas to move quickly to the designated shelter area.
   - Each supervisor will check all rooms in their area before taking shelter, unless there is imminent danger.
   - All employees will assist in moving patients in their areas to the designated area.
   - Pay special attention to patients who are in need of assistance and require the elevator to reach the shelter area. Reserve the elevator for those individuals who cannot use the stairs.
   - All employees must act calmly to prevent panic.
   - All electrical equipment should be turned off.

During a Tornado or Hurricane

The following safety requirements must be followed:
   - Stay away from open areas and windows in case of flying glass.
   - Do not leave the building unless told to do so. It is generally safer to be inside a building than outside.
   - If you are unable to reach the shelter area, take refuge under a desk or something sturdy.
   - If you are unable to evacuate or find a sturdy object for protection, lie on the floor with your hands covering the back of your head.

After a Tornado or Hurricane

When the danger has passed the supervisor will notify all employees and other when the all-clear signal has been given.
TORNADO or HURRICANE EMERGENCY ACTION PLAN

Evacuation

If a tornado or hurricane is imminent, all personnel shall evacuate the work area. Patients shall be directed to the designated shelter area (usually the basement). Turn off electrical equipment, check all rooms quickly and assist patients to safe areas. Remain calm.

Safety Requirements

- Stay away from open areas and windows in case of lying glass.
- Stay in the building unless told to leave.
- Go to the designated shelter area.
- If unable to reach the shelter area, take refuge under a desk or something sturdy. Avoid bookcases.
- If unable to do this, lie on the floor with your hand covering the back of your head.

For further information or explanation of this plan contact the safety coordinator.

This form should be copied and given to all employees upon completion of training.
Benchmark Physical Therapy Emergency Procedures

PURPOSE:

To establish a procedure in the case of a disaster.

POLICY:

It is the policy of BenchMark Physical Therapy to include disaster training in all orientation programs and provide no less than yearly disaster reviews to all employees.

A. Succession of Authority

1. Facility Administrator
2. Company President

The above persons will administer and coordinate the disaster procedures.

B. Classification of Disasters

<table>
<thead>
<tr>
<th>Disaster Situation</th>
<th>Clinic Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Disaster (within Physical Therapy clinic- Fire Explosion, epidemic, etc.)</td>
<td>Call fire department, attempt to put out fire, prepare to evacuate patients from threatened area.</td>
</tr>
<tr>
<td>External Disaster (outside the physical therapy clinic- storm, flood, tornado, explosion, epidemic, etc.)</td>
<td>Check with medical advisor and public health department as to part clinic may play.</td>
</tr>
</tbody>
</table>

PROCEDURE:

A. Notification

Call the following:

Local Fire Department ______________________________ or 911
Facility Administrator ______________________________
Company President ________________________________

B. All exits will be marked with exit signs.
C. Evacuation Route will be posted in all clinics.

D. BenchMark Management will be provided a report following any use of the Disaster Preparedness Procedures.

RESPONSIBILITIES:

Receptionist: Call 911 and report fire. Check the waiting area as well as make sure staff area is clear.

Therapist one: Check the exercise equipment area as well as exercise mat and treatment rooms one and two.

Therapist two: Check the restroom as well as balance of treatment rooms.

Follow evacuation plan as posted.

Drill dates, name and signatures of participants:

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
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<tbody>
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</tbody>
</table>

Created By: Dorothy A. Nobles  Approved By:  Date Distributed: 07/01/00
PURPOSE:

To ensure the well-being and safety of each and every patient treated in the clinic in the event of accident or sudden illness requiring urgent medical care. To provide for the protection of the patient and the personnel of the said outpatient clinic.

PROCEDURE:

1. The Physical Therapist or most qualified person will attend patient and administer urgent care.

2. The staff member will telephone: (1) Fire Department, (2) Para Medical Unit and request assistance, describe problem, and indicate what is being done, (3) Designated physician.

3. Patient's physician is notified by telephone.

4. Contact facility Medical Director.

5. A relative to contact in the event of an emergency is notified by telephone.

6. The Physical Therapist or other staff member attending victim will:

   a. Not attempt to move victim;

   b. Ensure that the victim has an open airway and administer cardiopulmonary resuscitation (CPR) if necessary;

   c. Control severe bleeding

   d. Protect the victim from unnecessary manipulation and disturbance;

   e. Maintain normal body temperature by covering victim to avoid or overcome chilling;

   f. Determine the injuries or cause of sudden illness, after immediate problems are under control.
PURPOSE:

The purpose of this policy is to establish a procedure to be used in case of an emergency at either the Business Office or clinical location.

PROCEDURE:

In the case of an extreme emergency dial 911.

Use your discretion in contacting the police or fire department. Contact the Business Office Manager as soon as possible after the initial contact.

Do not do anything that would jeopardize the patients, visitors or staff.

The police or fire department numbers are to be in a conspicuous area, preferably by a phone.
PURPOSE:

This policy is to provide guidance in the prevention of fire.

PROCEDURE:

Personal items that could cause a fire hazard (i.e. candles) are not allowed in the clinics/business office.
POLICY:

One of the serious problems confronting personnel is the hazard of fire. Therefore, this procedure is presented to help familiarize employees with their duties in order that the loss of life and property may be kept to an absolute minimum in the event of fire. It is the policy of BenchMark Physical Therapy to include fire prevention and training in all orientation programs and provide annually fire drills to all employees.

This policy and procedure is compulsory reading for all employees. It is to be read carefully by every member of the staff, so there will be no question as to what each will play, if and when, FIRE strikes. Read the policy and procedure carefully.

FIRE PREVENTION:

1. Good housekeeping is the best guarantee against fire. Do all you can to maintain order and cleanliness, in the interest of fire prevention. Make it a habit to watch for fire hazards.

2. Be alert for signs of fire — if you see or smell smoke, report it immediately for investigation. Early detection means prompt extinguishing of fire. Form habits of watchful care.

3. Know the location of fire extinguishers and exits in your area—know the different types of fires and be able to use the fire extinguishers properly. Go over the instructions you have been given on fire extinguishers. Knowledge now prevents panic later. Consult the fire evacuation chart. This chart will give you information on routing patients to the nearest exit, location of fire extinguishers and fire alarm boxes. Tour the building to make sure you really know the locations shown.

4. Never block fire exits or leave pieces of furniture, equipment, etc., so doors cannot close completely. At points throughout the building, there are smoke and heat detectors. These, as well as fire alarm boxes, will do several things when activated.

5. Staff and clients are prohibited from smoking in all areas except those designated.

6. Inflammable trash and rubbish will not be permitted to accumulate in or near buildings, offices, or other work areas. It will be collected in non-flammable receptacles and emptied when full, as needed.

7. Paints, oils, gasoline, kerosene, and other combustible materials will be stored only in approved containers and approved storage locations. Open paint cans will not be permitted in buildings, offices or general storage rooms.
8. NO SMOKING SIGNS shall be conspicuously posted in all areas which are considered fire hazards. All no smoking signs shall strictly be obeyed.

9. Vehicle parking is prohibited within fifteen (15) feet of fire hydrants, fire department connections and the building.
POLICY:

To establish the proper procedure in the case of a fire.

PROCEDURE:

Do Not Shout “FIRE” - Do Not Panic. Code Red should be announced.

1. Call fire department, report location, type and severity of fire.
2. Remove all patients from clinic.
3. Close doors, windows, shut off fans, electrical appliances.
4. Use fire extinguishers or blanket to smother fire. To operate fire extinguisher:
   a. Pull pin
   b. Squeeze handle
   c. Sweep back and forth under flames
5. Sound alarm if it has not already gone off.
6. Evacuate:
   A. Patients in immediate danger regardless of condition.
   B. Ambulatory patients - form chain and lead out of building
   C. Wheelchair patients by stretchers or carriers to nearest exit and then to parking lot.
   D. Helpless patients by stretchers or carriers to nearest exit, then to far corner of parking lot and assemble head count.
7. Business office- assemble valuables: patient records, payroll records, checkbooks, etc. to remove from building, if possible. Proceed to Exits.
PURPOSE:
To develop a procedure to find Material Safety Data Sheets (for safe handling of chemicals)

PROCEDURE:
There is an ICON located on each computer desktop named MSDS 2006. If you can not find the one on your desktop it is also located under Public/MSDS.

To find an MSDS using the entire database, click on "Template 1" to conduct a search. Enter your search request and click on OK. You will receive a Table of Contents for your search request. Once you have found the MSDS you wish to view, double click on that line and you will be taken to the full MSDS for that ingredient or product.
Alliance Physical Therapy

Maintenance

All electrical equipment will be checked by the therapist for frayed, broken, or damaged cords or plugs prior to each use.

All electrical equipment will be checked by the therapist for correct on/off, malfunctioning LED lights, and damage to the unit's outer casings prior to each use. Hot packs will be inspected monthly for leaks.

Maintenance for specific units will be as follows:

1. Hydrocollator Unit - Temperature will be monitored to maintain an operating temperature of 160-166 degrees. The unit will be cleaned and water changed every 4 weeks. The operating manual is kept on file in the department.

2. Paraffin Bath - Temperature will be monitored to maintain an operating temperature of 120-126 degrees. Paraffin mixture will be replaced on an as needed basis.

3. Exercise Bike/Stairstepper - Maintenance and service will be provided by the local bike dealer. Maintenance will be performed as needed.

4. Exercise Equipment - (Total Power, Uppercycle, Nautilus Abdominal/Extension, Treadmill, and all other equipment) will be checked monthly for integrity of springs, cylinders and knobs. Service will be provided by the individual manufacturing companies.

All electrical equipment/modality equipment will be checked and recalibrated (when appropriate) at least on an annual basis. This testing will be performed by qualified personnel and records will be kept.

Any equipment and/or supplies found to be faulty will be removed from inventory/use immediately and will not be returned to inventory/use until repairs have been completed and confirmed by re-inspection.
Preventative Maintenance Program for Equipment and Building

Routine checks of the MENS, Hydroculator, Electrical Stimulation, Ultrasound, Traction, equipment will be performed on not less than an annual basis by: (Company Name and Address)

Routine checks of TENS units will be performed by: (Company that owns equipment)

Electrical, plumbing, equipment, and general maintenance will be done bi-monthly or as needed by the tenant.

Housekeeping to be done daily by PT Aides and weekly by: Building Owners

All outside lawn care and snow removal done by: Building Owners

Fire extinguisher maintenance will be done annually by: Local Fire Department

Heating and Air Conditioning System will be maintained by: Building Owners

A file will be kept documenting all routine checks and maintenance on the MENS, Hydroculator, Electrical Stimulation, Ultrasound, Traction equipment, electrical and plumbing systems, and fire extinguishers.

It is the policy of Alliance Physical Therapy that:

1. Equipment will be checked monthly for any current leak or malfunction.
2. Any malfunction in daily use will be checked and fixed as soon as possible.
3. If there is any equipment failure, the machine will be posted out-of-order and will not be used on patients until repaired.
4. Ultrasound machines will be calibrated not less than annually.
5. In case of emergency on a malfunction, the servicing company will be called.
6. Sponges in the low voltage machines will be washed weekly to prevent any molding.
7. Paper towels are used over the sponges to keep sanitary conditions between patient uses.
**Electrical Maintenance**

All electrical machinery will be checked no less than annually. It will be seen that all electrical machinery is properly calibrated, etc., and that at no time will there be any voltage leakage. A file will be kept documenting all routine checks and maintenance of electrical equipment.

It will be up to the therapists to make sure that the equipment is in proper working order in between regular yearly checks by the electrical maintenance service. A file will be kept documenting all routine checks and maintenance of exercise and therapeutic equipment.

**Incident/Accident Reports**

If an incident occurs at Alliance Physical Therapy an Unusual Occurrence Report (UOR) will be completed and the UOR policy and procedures will be followed.

If an accident occurs at *Alliance Physical Therapy* an UOR will be completed and the UOR policy and procedures will be followed.

**The report includes the following:**

1. Date and time of the accident
2. Name of the victim
3. Age of the victim
4. Description of accident and injuries acquired
5. First aid treatment given
6. Medical authorities contacted

**Chemical Spill**

In the event of a local hazardous chemical spill, the building and all occupants will be evacuated from the building per the instruction of the proper government officials. The building will not be reoccupied until the proper government officials give their approval to return to the area.

Staff members should make sure that all patients leave the building and have transportation away from the contaminated area.
No staff member should stay in the building if government officials have given the order for evacuation. Prior to leaving the building, staff members should lock and secure the building per normal operating procedure.

**Tornado Policy**

*Tornado Watch:* weather conditions are such that a tornado is expected to develop.

*Tornado Warning:* a tornado has been sighted in the area.

If the National Weather Bureau issues a *Tornado Warning* to take cover, the clinic employees will take the patients to the center of the building. If patients can't walk, the therapist will carry the patients.

The assignment of personnel will be the same for tornadoes as stated in the Fire Policy.

If time does not permit evacuation of patients to the designated area, especially those who are immobile, the therapists will cover them with pillows, blankets, and/or mats as available.

A tornado drill will be conducted at least on an annual basis.

**Bomb Threat**

The secretary/receptionist will call the fire and police departments - Dial 911.

The assignment of personnel will be the same for a bomb threat as stated in the Fire Policy.

All available staff are to assist patients out of and away from the building.

If patients can't walk, a wheelchair will be used.

A bomb threat drill will be conducted at least on an annual basis.
**Hostage Policy**

Alliance Physical Therapy will follow the following procedures in case of a hostage situation:

Call the Police Department - Dial 911. They have procedures they follow in these situations. They do not make these procedures available to the public.

Isolate the situation as much as possible. Remove as many people out of the building as possible. Do not attempt to disarm or contain the individual(s).

Remain calm and wait for the police department.

**Natural Disaster**

It is the policy of Alliance Physical Therapy that in the event of a natural disaster (flood, earthquake, etc.) the staff of Alliance Physical Therapy use their best judgment to ensure their own and the safety of the patients.

Should evacuation of Alliance Physical Therapy be prudent, the staff shall assist patients from the building, assure that they have proper transportation or are safely moved away from the building and to a safe area.

Evacuation of the building shall be conducted according to the evacuation plan.
Bloodborne Pathogens Exposure Control Plan

In accordance with the OSHA Bloodborne Pathogens standard, 29 CFT 1910.1030, the following exposure control plan has been developed:

1. Exposure Determination

OSHA requires employers to perform an exposure determination concerning which employees may incur occupational exposure to blood or other potentially infectious materials. The exposure determination is made without regard to the use of personal protective equipment (i.e. employees are considered to be exposed even if they wear personal protective equipment.) This exposure determination is required to list all job classifications in which all employees may be expected to incur such occupational exposure, regardless of frequency. At this clinic the following job classifications are in this category: Physical Therapist; Occupational Therapist; Speech Therapist; Physical Therapist Assistant; Occupational Therapist Assistant; Physical Therapy Aide.

In addition, OSHA requires a listing of job classifications in which some employees may have occupational exposure. Since not all the employees in these categories would be expected to incur exposure to blood or other potentially infectious materials, tasks or procedures that would cause these employees to have occupational exposure are also required to be listed in order to clearly understand which employees in these categories are considered to have occupational exposure. The job classifications and associated tasks for these categories are as follows: None

2. Implementation Schedule and Methodology

OSHA also requires that this plan include a schedule and method of implementation for the various requirements of the standard. The following complies with this request.

Compliance Methods

Universal precautions will be observed at this facility in order to prevent contact with blood or other potentially infectious materials. All blood or other potentially infectious material will be considered infectious regardless of the perceived status of the source individual.

Work practice controls will be utilized to eliminate or minimize exposure to employees at this facility. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be utilized.
Center of Sports Medicine and Orthopedics

Emergency Procedures

Center of Sports Medicine and Orthopedics

CODE BLUE PROTOCOL

When a patient is found unresponsive or in obvious distress, announce on McCallie overhead page "CODE BLUE". Other locations:

The AED (Automated Electronic Defibrillator), Oxygen & supplies will be maintained in the clinic area at the satellite locations & in the MRI department at the McCallie office. A staff member in the area maintaining the AED will immediately take the AED to the area of the emergency.

If the Emergency is in the Clinic Area, the doctor, PA, nurse or Physical Therapist/Athletic Trainer will assess the patient and determine if further assistance is needed. The above personnel will directly contact or delegate someone to call 911 "CODE BLUE".

If the Emergency is in the MRI department, the employee(s) in the MRI department will call "CODE BLUE". The MRI staff will immediately undock the MRI gurney and move the patient and table outside of magnet room.

To call "CODE BLUE"

- **At McCallie Avenue office**, Dial 2999 on the nearest phone and announce CODE BLUE and the location three (3) times clearly and calmly
- **At Hixon/Atrium Clinics**, announce loudly (verbally) CODE BLUE and location
- **At Hixon/Atrium Physical Therapy**, announce in the physical therapy area and call respective doctor's line that a CODE BLUE is in progress -- send a staff member immediately to retrieve AED
- Assign someone to call 911 immediately
  - Indicate your location
  - Provide information as requested
  - The person assigned to call 911 should go directly to the entrance after notifying emergency personnel and await the arrival of EMS and direct them quickly to the code in process
  - Document events appropriately (treatment record) and attach in patients records.
- Clear area of unnecessary personnel including family members
- Other interventions as deemed necessary

If patient is unresponsive and no pulse or respirations are identified the trained health care provider in closest proximity will follow BLS/ACLS protocol until ambulance arrives to transport to emergency room.
The designated trained staff member appointed will be responsible for communicating with the appropriate members of the local authority. This should be documented and recorded.
CODE YELLOW PROTOCOL

When a patient is found engaging in behavior that is threatening, intimidating or coercing to another employee, patient or member of the practice, announce on the overhead page “CODE YELLOW” and their location. Other locations: Go into hallway and announce loudly "CODE YELLOW". This prohibition includes all acts of harassment, including both indirect and direct threats of violence. A member of the management staff or physician/lead team member will report to your area to address the occurrence.

All suspicious individuals or activities should be reported as soon as possible to a member of the management team. Do not place yourself in peril. If you see or hear a commotion or disturbance near your workstation, do not try to intercede or see what is happening. The goal of the Center is to maintain workplace safety and integrity. Contact your supervisor before the situation escalates into potential violence.

The management team member or person leading in the situation will determine the appropriate course of action to take.

To call “CODE YELLOW”

- **McCallie:** Dial 2999 on the nearest phone and announce CODE YELLOW and the location three (3) times clearly and calmly; **Gunbarrel:** Dial 3999 on the nearest phone and announce CODE YELLOW and the location three (3) times clearly and calmly; **Hixson:** Go into the hallway and announce loudly CODE YELLOW
- If determined necessary by management staff, they will assign someone to call 911
- Indicate your location
- Provide information as requested, be as specific and detailed as possible
- Document events appropriately (incident report) and attach in patient’s records.
- Other interventions as deemed necessary

All appropriate management staff will respond to the CODE YELLOW. When it is apparent that sufficient staff is present, the excess personnel will be directed to return to their workstations.
North River Physical Therapy

Emergency Policies and Procedures

EMERGENCY PROCEDURES

I. Non-Medical
   A. All action must be taken quickly without sign of panic or hysteria on the part of the employee.
   B. First person to observe sign of emergency (fire, explosion, etc.) shall notify receptionist and/or pull alarm.
   C. Receptionist shall notify employees of emergency situation. She will then contact proper authorities (fire department, police department, etc.)
   D. Therapists and assistants will be responsible for evacuating patients from treatment areas in accordance with routes posted in each area, and according to location and type of emergency code given by receptionist.
   E. Receptionist and other front office personnel will be responsible for evacuating waiting room and restrooms.
   F. After all patients have been evacuated, in case of fire, efforts shall be made by available personnel to extinguish fire with hand portable unit. This step is not to be followed if danger to employee exists.
   G. Physical therapy aides will be responsible for turning all thermostats off and closing all doors and windows that would restrict the spread of smoke and gases. Administrator or Assistant Administrator is responsible for turning gas off to building.
   H. Control of activities shall be turned over to the proper authorities when they arrive.

II. The Following Shall be Checked Annually and a Report Filed at That Time:
   A. Fire: Extinguishers: All extinguishers in designated locations, to be unobstructed and ready for instant use. No leaks, corrosion or other defect noted.
   B. Exit: Furniture placed so patients can quickly and safety evacuate rooms. Corridors and steps unobstructed.
   C. Electrical Wiring and Equipment: No multiple wiring connected to wall outlets. All lamp and appliance cords free from wear and not installed under rugs or fabrics. Light bulbs free from contact with combustibles.
   D. Storage and Waste Disposal: Brooms, mops, rags, and other cleaning supplies to be stored in a safe place. Flammables stored in a metal cabinet. Combustibles set clear of stoves, heating appliances, and water heater.

III. Tornadoes
   A. The Administrator is responsible for and employees are expected to assist in preparing their respective area for tornado protection as instructed during our Emergency Drills.
   B. All movable equipment is to be placed in empty exam rooms or other closed area to prevent injury to patients.
   C. Move patients to interior areas and follow proper protection procedures.
   D. The Facility shall be closed when the Weather Bureau designates that the area in which the facility is located is in a state of Tornado Warning. The Administrator has the authority to make any necessary changes in these policies.

IV. National Disasters or Emergencies
   A. In the event of a National emergency or disaster, receptionist will turn radio to Emergency Broadcast System for instructions. Administrator will be notified as to latest report.
B. All available personnel will assist in the evacuation of patients and any other necessary preparation as instructed by the Emergency Broadcast System and in proper sequence as practiced in our annual drills.

V. Medical Emergencies
A. In the event of a medical emergency within the Facility, the following criteria shall be observed:
   1. The Physician on call shall be the physician on call for NGPT/NRPT. This will be posted the first of each month.
   2. Administer first aid as indicated.
      a. Air mask is located in the first-aid box.
   3. Contact patient's physician immediately if the physician on call is not the patient's physician.
   4. Contact Facility's Administrator.
   5. Remain calm and attempt to prevent unnecessary concern or panic in the immediate area.
   6. When patient is in proper medical hands, report to proper authorities, and complete a written report and file in patient's chart.

VI. Specific First Aid Procedures
A. Seizures
   1. Get patient into bed or surface where he can be turned on his side and restrained sufficiently to prevent injury.
   2. Use padded tongue blade or other blunt object to protect tongue.
   3. Nothing by mouth.

B. Burns
   1. Remove clothing over burns if not adherent to skin, if adherent gently cut clothing away.
   2. For first-degree burns, cleanse area and apply dressing if needed.
   3. For second or third degree burns, if medical attention is not available, cover area with sterile dressing. DO NOT APPLY OIL OR OINTMENT.

C. Fainting
   1. Place patient in lying position with head lower than rest of body.
   2. Loosen any tight or binding clothing.
   3. See that the patient has sufficient air.
   4. Administer aromatic spirits of ammonia by inhalation.

D. Respiratory Arrest
   1. Establish an open airway.

If patient does not resume spontaneous breathing:
   2. Tilt the head back, while lifting the lower jaw upward.

If patient still does not begin breathing:
   3. Check for obstruction in the airway and begin ventilation.
   4. Continue ventilation until a medical authority arrives and advises operator to cease.
E. Cardiac Arrest
   1. Administer closed chest massage.
   2. Begin mouth-to-mouth resuscitation.

F. Falls
   1. Head Injuries
      a. If patient is unconscious, place in recumbent position with feet higher than head.
         Turn head to side to allow secretions to drain.
      b. Loosen clothing about the neck.
      c. Apply sterile dressing if scalp wound is present.

   2. Fractures
      a. Keep patient quiet and warm.
      b. Immobilize affected part.
      c. Treat for shock if necessary.

   3. Minor Cuts and Bruises
      a. Wash area
      b. Apply sterile dressing PRN.

VII. All Employees will be required to attend periodic in-service training which will expose them to emergency first aid techniques and demonstrate at that time evidence of an applicable knowledge of proper procedures by correct application in simulated emergencies.

All emergencies, medical and non-medical, have been reviewed and approved by the Facility's Advisory Board.
EARTHQUAKE

The movement of the ground is seldom the direct cause of death in an earthquake. Most deaths and injuries are caused by falling objects and debris, flying glass, fallen power lines, and fires from broken gas lines.

Before an earthquake, if we have advanced notice, we should:

1. Bolt down or stabilize water heaters, stoves, and any other gas appliances.
2. Brace or anchor tall and top-heavy furniture.
3. Remove large or heavy objects from shelves.
4. Know how to shut off electricity, gas, and water at main switches. Keep a wrench near shut-off valves.

During an earthquake:

1. Get under a table, desk or bed. Other areas of shelter are strong doorways or corners away from windows.
2. Be aware of high bookcases, cabinets and shelves that could topple.
3. Stay away from windows, mirrors and chimneys.
4. If outdoor, move to open area away from buildings, walls or utility poles.
5. Leave areas with wide-span ceilings, such as gymnasiums and shopping mall walkways - no additional support of inner walls.

PROCEDURES:

In the event of earthquake warning, the following procedures are to be followed:

1. Receptionist will alert entire building with a page-all alert stating, "Quake alert—begin emergency procedures.” This will be repeated three (3) times.

2. Clinical staff will remove all patients from treatment areas away from windows. Close all doors going to exam rooms and gym area to prevent flying glass injuries. Remove all equipment in modality area and put in exam rooms.

3. Patients should be placed in modality area in crouched position instructing them to keep heads and back of neck protected. Clinical staff should remain in this area with patients.

4. Clinical staff will remove all persons from lobby and restrooms, placing them in modality area.

5. Clerical staff will get under their desk, protecting their heads and back of neck.

6. Receptionists need to get away from front desk light and windows. can share desk with one of the other clerical staff.
7. Therapist need to leave their positions on the top level and get under desk with clerical staff members.

8. Administrator, or in his absence, the Assistant Administrator, will be responsible for shutting off electricity, gas, and water at main switches.

All personnel and patients are to remain in protected areas until shaking stops and Administrator or Assistant Administrator has given an all clear.
IN-SERVICE

EMERGENCY PROCEDURES - FIRE

There are 7,000 office fires annually with deaths. Arson is the largest single cause.

All staff members need to be advised at time of employment, as well as refreshed annually, regarding emergency procedures.

1. Learn two escape routes from all work areas, as well as distance to these exits in case of dense smoke.

2. Location of all pull alarms (back door, front door, two in gym, Hand Clinic door, and modality area). Pull alarms are activated by gripping pull lever with fingers and pulling in a downward motion. In case of false alarm, system is reset in furnace room and staff will be notified by intercom to disregard alarm.

3. Location of fire extinguishers (front door, inside business area on wall by doorway leading to reception desk, gym, and top of stairway on upper level). Fire extinguisher is activated by pulling ring, hold upright, stand ten feet from fire and aim at base of fire with a sweeping motion. Only to use extinguisher if danger of being trapped does not exist.

4. Remember that smoke rises, so breathing and visibility will be best nearest to the floor. If heavy smoke is present, move in crawling position to nearest exit. If necessary, put patient on sheet and pull out.

5. Do not try to be a hero—your safety is just as important as the patient's.

In case of fire, follow these steps:

1. Person discovering fire should pull alarm and then notify receptionist. If small fire, fire extinguisher should be activated.

2. Receptionist will do a Page-All stating a Code Red, giving location. She will then call the Fire Department instructing them of proper address and that there are people in the building. She will wait outside for them to arrive. If phones are not operating, receptionist will go to closest facility and phone.

3. Clinical staff will evacuate all patient areas quickly, but calmly. Leave exam room doors open after evacuating patient unless fire has originated in that room. Close main doors separating work areas. Before entering any area with closed door, feel for heat. If hot, brace body against door and open slightly. Close if smoke or flames are present. Clear all patients from each area before exiting—re-entering has cost many lives.
4. If fire is preventing escape, wet your clothes and patient's clothes, cover head and neck with wet towel and quickly exit.

5. Break window with chair as last resort if flames are present. Flashbacks are deadly.

6. Clerical staff will evacuate front lobby and restrooms, as well as staff lounge area and dictating area.

7. After evacuating building, move away from the building. Stay out of the way of the Fire Department. Stay with the patients—DO NOT re-enter the building until Fire Department gives all clear.
TORNADO

1. Thunderstorms:
   A. May produce:
      a. Rain show.
      b. Thunder and lightning
      c. Small hail less than 3/4" in diameter
      d. Wind gusts up to 50 mph
      e. Major damage is rare
   B. Precautions:
      a. Do not use telephone
      b. Avoid hilltops and under trees
      c. Leave water
      d. Avoid open areas
      e. Car with windows rolled up good
      f. Get away from lawn mowers, golf carts, tractors, bicycles
      g. if caught in a boat, curl up in ball and stay low

2. Severe Thunderstorm
   A. May produce
      a. Frequent lightning
      b. Heavy rain
      c. Hail larger than 3/4" in diameter
      d. Wind gust over 50 mph
      e. Can cause considerable damage

3. Tornado watch
   A. Means:
      a. Conditions are right for tornado
      b. usually issued 4-6 hours prior to tornado
      c. thunderstorm usually has not developed
   B. Precautions:
      a. Watch sky
      b. Monitor radios
      c. Be prepared to move quickly to place of safety if threatening conditions arise
4. Tornado warning

A. Means:
   a. Tornado sighted or detected by radar
   b. Covers short period of time—issued on a county basis
   c. Warning message will include last position of storm
   d. Take shelter immediately

5. Tornado

A. Means:
   a. Most violent storm of the atmosphere
   b. Wind speeds possible over 200 mph
   c. Serious damage and injury may result from falling structures and flying debris

General instructions for emergency procedures are as follows:

1. Stay away from all windows
2. If you have a basement, go to it, get under sturdy bed or table pulled up against a wall
3. Do not get in a crawl space
4. Get in an interior closet
5. Get under heavy furniture in center of house
6. If in your car, pull off road, lie down in lowest place available away from your car (i.e., ditch), and cover your head

In case of severe weather conditions, radio in Facility will be monitored by receptionist and a physical therapy aide. Administrator, Assistant Administrator or immediate supervisor should immediately be notified when a tornado watch has been issued. Radio will continue to be monitored for any update.

In case of tornado warning being issued, Administrator will notify staff members to immediately begin the following emergency procedures:

Evacuate all treatment areas immediately. Clinical staff should move all patients to safety of inner hallways away from all windows. Doors should be closed to prevent flying glass from reaching patients. Receptionists are responsible for persons in the waiting area. In the hallway, patients are to be placed in a crouched position, face turned towards the wall, and arms covering head. Patients and therapists are to remain in this position until all-clear signal is given by management.
Emergency Action Plan for McCallie Athletics

Personnel:

The personnel involved in the coverage of athletic events and practices include, but are not limited to the following: Head ATC, Assistant ATC, Athletic Training Students (ATS), Attending Physicians, and Emergency Medical Support Teams.

All ATCs will have NATABOC certification and hold licensure within the State of Tennessee. All ATCs and ATSs will have certification and proficiency in the areas of basic or advanced first aid, cardiopulmonary resuscitation, and be able to operate an automated external defibrillator. Physicians, if present, will take charge of emergency care situations and be familiar with the school’s emergency action plan.

Emergency Medical Support Teams will be required for all emergency injuries and illnesses which require medical transport in an ambulance and in all cases that require spine-boarding or immobilization. The aforementioned staff will be required to assist the Emergency Team in whatever role is necessary (Spine-boarding, crowd control, etc.).

Event and practice coverage:

An attending physician will be present at all varsity football games.

Priority for coverage by an ATC first goes to home competitions and those that have the highest risk of injury (i.e. Football, lacrosse, soccer, wrestling, baseball, and basketball). An ATC will be present at all football competitions and all varsity and junior varsity practices. Home competitions including these events: cross country, track, crew, swimming, tennis, golf, water polo, and teams below the varsity level of competition (with the exception of football) usually are not provided with direct coverage by an ATC.

Coverage for away competitions will depend on home events and availability of staff, however coverage may be arranged with local trainers for trips to Knoxville, Nashville, or Memphis.

Equipment:

Training kits are available for home and away competitions and are stored in the training room and are to be returned as soon as possible after the event.

Training kits are to be on-site with an ATC during practice and games and will have emergency equipment that includes, but is not limited to first aid supplies, glucose syrup or tablets, and other taping, bracing, medications, personal protective equipment and bio-hazard bags and an epi-pen. The epi-pen should be inspected for expiration by the ATC before the kit is available to be taken out again. Within each kit there should be a concussion screening card in the instance that an athlete should suffer a head injury and the coach should follow the guidelines on the screening card to determine what actions need to be taken in the event a certified athletic trainer is not present.
Durable emergency equipment such as splints, crutches, and spine boards are also located in the athletic training room, but are brought to the field of play of the event being covered (in most instances football). An Automated External Defibrillator (AED) will be present at all games being covered by the head ATC or the event with the highest number of people (athletes, bystanders, and other individuals). It is the responsibility of the ATC to bring the AED to the field of play and to check the batteries before each event. The AED is stored within the athletic training room.

In case of an emergency in a location that lacks ATC coverage it is the responsibility of the coach to contact the Head ATC, who will either delegate or visit the site himself with the appropriate emergency equipment using whatever means is quickest.

**Communication:**

All emergency calls will be initiated through the office of school security. The security officer on duty will call 911, campus security (667-6045). If the injury warrants, the ATC will call the student’s parents, and if applicable, the student’s dorm advisor. As well as Sumner McCallie (667-4649), Kenny Sholl (413-4439), or Kirk Walker (240-9551). The athletic trainer will call and instruct the ER staff to any pertinent medical history.

All ATCs should be reachable by cell phone during events and practices. ATCs will also be able to communicate by way of walkie-talkies in order to orchestrate logistics.

All coaches will have the Head ATCs phone number as well as the number to the infirmary, and 911. If a coach does not have a cell phone, cell phones are provided.

If the ATC determines that medical treatment is needed in the case of a day student the parents will be contacted, and in a boarding student the infirmary will be contacted. The team physician will be consulted and the athlete transported to the appropriate medical clinic or emergency room.

For non-emergency referrals of boarding students the infirmary will be responsible for making general medical appointments. The ATC’s will provide an injury report in case a referral is made for an orthopedic injury by the ATC. The ATC may assist in securing an orthopedic physician appointment.

Parents will be contacted if a referral is needed for a non-emergency appointment in the case of a day student and the decision is then the parent’s to make. The infirmary will also be notified. The infirmary or the ATC can set up the appropriate appointment at the parent’s request.

In case of an emergency the infirmary or ATC will notify the parents and the Executive Director of Operations will notify the School’s Insurance Policy. No student should be taken or sent to the emergency room without having their insurance information and release to treat forms either with them on the way to the hospital or faxed to the hospital.
by the infirmary. Forms are located in the infirmary and copies are available in the Athletic Training Center.

**Transportation:**

If the decision to transport or send an injured or ill athlete to the emergency room is made it is required that a member of the sports medicine staff accompany that athlete to the emergency room. A company vehicle should be used in these instances, however, if a personal vehicle is used than the school will cover any costs from damages or soiling of the vehicle.

In case any student requires transport to the emergency room at any time, a faculty or staff member will be required to accompany the student.

**Venues:**

For football games and practices at least one ATC will be present. During games emergency medical professionals should be present for immediate emergency care and emergency transport. For football practices the covering ATC will first respond to the emergency, then determine if emergency response is required. If required the ATC will initiate the call through the office of security where the security officer will instruct the ambulance service to respond to the area and enter the School through its main entrance on Dodds Avenue across from Bailey Avenue and, once on campus, security officers will direct the ambulance to the injured athlete. Security officers and the Athletic Training staff will stay in communication through two-way radios or cellular phone contact. Then proceed to the football field where the gate will have been opened to the upper field, if the emergency has taken place on the game field.

This following procedure will be followed for emergencies that take place on the soccer field, but the ambulance would then be instructed to drive to the soccer field to meet the emergency. For emergencies that occur in the Sports and Activities Center (i.e. swimming, basketball, weightlifting, and all other activities) EMS should arrive through the main entrance and follow the road through campus, taking a left on Kyle St. which leads to the rear entrance to the Sports and Activities Center.

For emergencies that take place at the varsity baseball field EMS would enter the campus through Kirby Avenue and meet the sports medicine staff at the varsity baseball field. The same entrance will be used to access the practice baseball fields and tennis courts. Again, Campus Security will aid the EMS service to the injured athlete.

**Procedures for Common Situations:**

Lighting activity: The Athletic Trainer will be responsible for making the decision to suspend activities due to lighting activity. Suspension of activities includes all practices or competitions that take place outside will be delayed or paused and moved inside. Each field
of play will have a designated safe shelter that will be used in case a lighting storm arrives during the course of a competition or practice. The decision to postpone all outside activities will be called when the mobile lightning detector indicates danger, or if the lightning detector is not available, the flash to bang method should be used. If a peal of thunder is heard 30 seconds or less after a flash of lighting the risk is great enough to bring an event inside.

If the decision to evacuate the fields of play is made then the lines of communication will follow as such. The ATC that discovers the risk for lightning should contact the Head ATC who will then contact coaches and any other ATC on staff that all individuals should be moved inside. Lines of communication will include cell phones and walkie talkies, if these lines of communication are unavailable or the coach does not respond it is imperative that the ATC delivers the message that all athletes and personnel need to go inside. All athletes will report to the Sports and Activities Complex.

Lightning Strike: If an athlete, coach or official is struck by lightning the following procedures should be conducted: The ATC will instruct a coach to call 911. The first step is to evaluate for airway, breathing, and circulation. Also, evaluate the scene to assess personal safety for further action. The athlete should be moved to a safer location only if a head or neck injury is not suspected, if a head or neck injury is suspected care must be delivered on the field. Begin CPR if it is necessary. The athlete should also be treated for hypothermia and shock. Any evaluation of burns or injury should do so after the patient is stabilized and in the care of the emergency responders.

Excessive Heat: McCallie School as a member of the TSSAA must comply with the minimum standards of adjustment to prevent heat illness and potential death in association with high heat indexes. The conditions provided for under the new TSSAA guidelines call for optional water breaks of ten minutes every half hour with ample water and ice towels provided when the heat index is below 95 degrees. Athletes should still be monitored for the signs of heat illness. When the heat index is between 95 and 99 degrees call for mandatory water breaks every half hour, again ample water and ice-down towels should be provided. Excess equipment should be removed when not in use and the duration of exposure should be limited. Consideration of postponing practice until later in the day may be needed and the heat index should be reestablished every 30 minutes to account for any increase. When the heat index rises to 100-104 degrees all prior efforts should be made and a strong consideration to move practice inside, or limit practice time should be taken. Uniform and equipment alteration is required, if padding or helmets are required for safety then that activity should be cancelled. When the heat index is above 105 degrees all outside activities must be cancelled and inside activities as well, when no air conditioning is available.
The heat index will be taken on the field of play by the ATC using a sling psychrometer. This information will be provided to the coaches to discuss a strategy if alterations must be made. More details about the TSSAA position on heat illness can be found at http://www.tssaa.org/handbook/heatpolicy.htm.

Heat Illness: All athletes should be monitored during excessive heat. If an athlete appears confused, lethargic, dizzy, or lightheaded then send that athlete to the ATC for further evaluation. The suspected athlete should be removed from the session if they are suffering these symptoms, moderate means of body heat reduction should be used (i.e. fluids, cooling towels, shade, and a fan or mister). If that athlete begins to report an increase of symptoms, pale skin, rapid and shallow breathing or a weak pulse then heat exhaustion should be suspected. The athlete should be treated with similar procedures, but the ATC should alert or transfer the athlete to local emergency care facilities. If a rectal temperature is obtained and is above 104 degrees Fahrenheit then heat stroke is present. The athlete may also have hot and possibly dry skin, red skin, a strong and rapid pulse, lethargy and nausea, an altered mental status, or the athlete loses consciousness. In this case 911 should be called and the athlete removed from the situation, assess cognitive function, remove all excess clothing, and submerge the athlete in cool water. During this time the airway should be maintained if the athlete is unconscious. The athlete should be transported to the emergency room as quickly as possible.

Tornado or Other Storms: The course of action for tornadoes and other forms of serious wind storms is similar to the plan followed by the lighting protocol. If a severe weather advisory is released for the Hamilton County area then all outside practices and all inside practices that occur in close proximity to windows will also be cancelled. Athletes should all report to the hallway and corridor between the weight room and equipment managers office.
Fire: In case of a fire emergency the fire alarm should be pulled by a member of the staff if the alarm has not already been activated. All posted evacuation routes should be followed and all athletes, staff, officials, and bystanders should evacuate through the indicated route quickly and safely and stand clear of the building without impeding fire lanes. 911 should be called by a member of the athletic training staff to prevent numerous calls to the fire department.

Unconscious person: The ATC should not attempt to move the athlete unless head or neck injury is completely ruled out. The ATC should monitor airway, breathing, and circulation and perform CPR if needed at this time 911 should be called to send for help. If the AED is needed then a member of staff should be delegated with retrieving the AED. If the person is breathing maintain observation of vitals until help arrives to transport or the athlete regains consciousness.

Seizure Victim: If the ATC is on the scene he should clear space around the victim if they are convulsing to prevent injury and possibly pad any potential dangerous objects that could not be moved, the head could be supported as well. After the seizure keep the victim quiet and comfortable until help arrives. Do not put any object in the victims mouth at any time.

Excessive Bleeding: The ATC should apply direct pressure with clean cloth or gauze until bleeding stops or the athlete has been transported to the emergency room. If the wound does not requires stitches (<1 in. length and <.25 inches wide) then it should be cleaned, bandaged and monitored for infection. Do not apply excessive pressure if you suspect a fractured bone at the injury site.

Diabetic Coma or Shock: Know the athletes history, they might not have an identification bracelet or necklace. The ATC should monitor breathing and circulation. If the victim stops breathing administer rescue breathing or CPR. In this instance 911 should be called. Monitor the condition until help arrives.

Anaphylactic Shock: Know the history of the athlete and ask for a history if the athlete is able to provide it, if not, try to obtain the history from a witness. The ATC should confirm that the athlete’s airway is being compromised or reactions on the skin are forming before using the athlete’s epi-pen. The epi-pen should not be administered by an individual other than the ATC or the athlete themselves. The athletes should be transported to emergency care facilities even if their condition appears to be stabilized.

Head injury: The ATC should be aware of an athlete that is acting abnormally and attempt to get a history from that athlete even if they do not seek out the ATC for themselves. The head injury can be screened using a screening card or another appropriate series of tests that cover anterograde and retrograde amnesia, as well as short term memory, and a qualitative cognitive question (count backwards from 100 by 6’s). Balance and other symptoms such as nausea and headache should be accounted for. If the athlete losses consciousness during any point then they should be transported to the emergency room. The grade of the concussion will be used to determine further treatment.
In any instance where the AED or other emergency equipment is required a member of the athletic training staff should be present or able to retrieve that item.

**Implementation:**

All coaches and other staff (Equipment manager, Strength and conditioning coaches, etc.) should be aware of their responsibilities and roles during an emergency situation and expect to follow any orders given by an Emergency Responder, Physician, or ATC. Also, compliance with all coaches on implementation of adjustments that must be made in accordance to the TSSAA position statement on heat illness is necessary in order to protect the athletes of the institution.

In services to discuss and practice emergency procedures are to be held before each sport season and written copies of the specific expectations are to be provided to coaches and other staff. In-service for all staff will be provided so concerns that face all students and staff (Fire, storms etc.) can be properly handled and each member of staff is aware of evacuation routes and designated areas which are safe in times of emergency. The institution is responsible for holding regular planned fire drills and tornado drills.

Contact lists will also be shared and kept in the training kits and posted in coaches’ offices and in the athletic training room. A copy of the emergency action plan will be posted next to the phone in the athletic training room.

**McCallie Medical Phone List:**

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head ATC</td>
<td>Jersey DeMarco, ATC</td>
<td>423-667-5556</td>
</tr>
<tr>
<td>Asst. ATC</td>
<td>Bryan Beasley, ATC</td>
<td>423-242-8839</td>
</tr>
<tr>
<td>Asst. ATC</td>
<td>David Sewell, ATC</td>
<td>423-240-1586</td>
</tr>
<tr>
<td>Team Physician</td>
<td>Dr. David Bruce</td>
<td>423-893-9020</td>
</tr>
<tr>
<td>Team Physician</td>
<td>Dr. Kurt Chambless</td>
<td>423-893-9020</td>
</tr>
<tr>
<td>McCallie Infirmary</td>
<td>Lisa Hobbs, RN</td>
<td>423-493-5640</td>
</tr>
<tr>
<td>McCallie Security</td>
<td>Burt Gould</td>
<td>423-667-6045</td>
</tr>
<tr>
<td>Athletics Director</td>
<td>C.R. Bubba Simmons</td>
<td>423-493-5530</td>
</tr>
<tr>
<td>Parkridge Emergency Room</td>
<td></td>
<td>423-493-1493</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td></td>
<td>911</td>
</tr>
</tbody>
</table>
Ooltewah High School

Athletic Emergency Action Plans
Ooltewah High School Athletic Department
6123 Mountain View Road
Ooltewah, TN 37363

EVACUATION ROUTES

- Evacuation Routes have been posted in each area of all athletic facilities. The following information is marked on each evacuation map:
  - Emergency exits
  - Primary and secondary evacuation routes
  - Locations of fire extinguishers
  - Fire alarm pull stations’ locations
  - Assembly points
- Site Personnel should know at least two evacuation routes

EMERGENCY PHONE NUMBERS

Emergency: 911

Fire Department: (423) 894-5231

Paramedics: (423) 892-2120

Ambulance: (423) 499-9500

Police: (423) 396-3135

Federal Protective Service: (423) 634-6624

UTILITY COMPANY EMERGENCY CONTACTS

Electric: EPB Electric Company
   (423) 238-6550

Water: Tennessee America Water
   (423) 892-1308

Gas: East Tennessee Natural Gas Company
   (423) 344-1103

Telephone Company: AT&T
   (423) 238-1674
EMERGENCY REPORTING AND EVACUATION PROCEDURES

Types of emergencies to be reported by site personnel are:

- MEDICAL
- FIRE
- SEVERE WEATHER
- EXTENDED POWER LOSS

MEDICAL EMERGENCY

Basic Components of the Medical Emergency Plan:

- In any athletic association competition or practice, the first responder usually is a member of the sports medicine team. This includes a certified athletic trainer (Randy Wilkes), a doctor, or a school nurse. The athletic trainer will give priority to practices and games based on the risk level of each in-season sport. After 3pm, the athletic trainer is the only medical responder on site.
- Each football game (fall) has a fully-stocked athletic training bag, an Automatic External Defibrillator (AED), and a spine board is not on site. The ATC is also required to carry a cellular phone at all times in case of an emergency.
- However, in the event there is not a member of the sports medicine team readily available for first response, it may be a coach or other institutional personnel. Certification in cardiopulmonary resuscitation (CPR), first aid, prevention of disease transmission, and emergency plan review is required for all athletics personnel associated with practices, competitions, skills instruction, and strength and conditioning. Copies of training certificates and/or cards are maintained in the athletic director’s office.
- These steps should be followed in the event of any emergency:
  - Call necessary medical personnel and 911 protocol if needed (located above):
    - Paramedics
    - Ambulance
    - Fire Department
  - Provide the following information:
    - Nature of medical emergency
    - Location of the emergency (address, building, room number)
    - Your name and phone number from which you are calling.
  - Do not move victim unless absolutely necessary.
  - Call the following personnel trained in CPR and First Aid to provide the required assistance prior to the arrival of the professional medical help:
    - Randy Wilkes (Athletic Trainer): (423)298-4643
  - If personnel trained in First Aid are not available, as a minimum, attempt to provide the following assistance:
    - Stop the bleeding with firm pressure on the wounds unless bleeding is occurring at site of protruded fracture (note: avoid contact with blood or other bodily fluids).
- Clear the air passages using abdominal thrusts in case of choking.
- Attempt first aid ONLY if trained and qualified.
- All emergency patients will be directed to the hospital based on the location of the venue (Home/Away), insurance type, recommendation of the Emergency Medical Technicians and the severity of injuries.

**FIRE EMERGENCY**

*When fire is discovered:*
- Activate the nearest fire alarm
- Notify the local Fire Department by calling (numbers located above)
- If the fire alarm is not available, notify the site personnel about the fire emergency by the following means:
  - Voice Communication
  - Phone
  - Radio

*Fight the fire ONLY if:*
- The Fire Department has been notified.
- The fire is small and is not spreading to other areas.
- Escaping the area is possible by backing up to the nearest exit.
- The fire extinguisher is in working condition and personnel are trained to use it.

*Upon being notified about the fire emergency, all occupants must:*
- Leave the building using the designated escape routes.
- Assemble in the 4 designated areas: Parking Lots farthest away from school building; Baseball Parking Lot, Football Parking Lot, Teachers Parking Lot, and Green Parking Lot.
- Remain outside until the competent authority (Designated Official or designee) announces that it is safe to reenter.

*Designated Official, Emergency Coordinator or supervisors must:*
- Principle, Vice Principle and Office Personnel divide radio units and identify the initiation, carrying out, and completion of all fire evacuations.
- Disconnect utilities and equipment unless doing so jeopardizes his/her safety.
- Coordinate an orderly evacuation of personnel.
- Perform an accurate head count of personnel reported to the designated area.
- Determine a rescue method to locate missing personnel.
- Provide the Fire Department personnel with the necessary information about the facility.
- Perform assessment and coordinate weather forecast office emergency closing procedures

*Area/Floor Monitors must:*
- Ensure that all employees have evacuated the area/floor.
- Report any problems to the Emergency Coordinator at the assembly area.

*Assistants to Physically Challenged should:*
- Assist all physically challenged employees in emergency evacuation.
SEVERE WEATHER AND NATURAL DISASTERS

Lightening:
- If lightening and/or thunder can be seen or heard, stop activity and seek protective shelter immediately and:
  - An indoor shelter is recommended; however, if indoor shelter is not available, an automobile is a relatively safe alternative.
  - All athletes and coaches will be instructed under the athletic trainer to follow procedure to the nearest predetermined location depending on the sport, while all spectators are encouraged to return to their vehicles or inside the school building when appropriate.
  - If none of these options are available, avoid standing under large trees or telephone poles.
  - If the only alternative is a tree, choose a small tree in a wooded area that is not on a hill.
  - As a last alternative, find a ravine or valley.
  - In all instances outdoors, assume the crouched position using arms to protect head and neck.

Tornado:
- When a warning is issued by sirens or other means, seek inside shelter. Consider the following:
  - Small interior rooms on the lowest floor and without windows
  - Hallways on the lowest floor away from doors and windows
  - Rooms constructed with reinforced concrete, brick, or block with no windows
- Stay away from outside walls and windows.
- Use arms to protect head and neck.
- Remain sheltered until the tornado threat is announced to be over.

Earthquake:
- Stay calm and await instructions from the Emergency Coordinator or the designated official.
- Keep away from overhead fixtures, windows, filing cabinets, and electrical power.
- Assist people with disabilities in finding a safe place.
- Evacuate as instructed by the Emergency Coordinator and/or the designated official.

Flood:
If indoors:
- Be ready to evacuate as directed by the Emergency Coordinator and/or the designated official.
- Follow the recommended primary or secondary evacuation routes.
If outdoors:
- Climb to high ground and stay there.
- Avoid walking or driving through flood water.

Hurricane:
• The nature of a hurricane provides for more warning than other natural and weather disasters. A hurricane watch issued when a hurricane becomes a threat to a coastal area. A hurricane warning is issued when hurricane winds of 74 mph or higher, or a combination of dangerously high water and rough seas, are expected in the area within 24 hours.
• If threat has been identified, all sporting activities will be cancelled and students and faculty will be sent home.

*Once a hurricane watch has been issued:*
• Stay calm and await instructions from the Emergency Coordinator or the designated official.
• Continue to monitor local TV and radio stations for instructions.
• Move early out of low-lying areas at the request of officials.
• If you are on high ground and plan to stay, secure the building, moving all loose items indoors and boarding up windows and openings.
• Collect drinking water in appropriate containers.

*Once a hurricane warning has been issued:*
• Be ready to evacuate as directed by the Emergency Coordinator and/or the designated official.
• Leave areas that might be affected by storm tide or stream flooding.

*During a hurricane:*
• Remain indoors and consider the following:
  o Small interior rooms on the lowest floor and without windows
  o Hallways on the lowest floor away from doors and windows
  o Rooms constructed with reinforced concrete, brick, or block with no windows.
EXTENDED POWER LOSS

In the event of extended power loss to a facility certain precautionary measures should be taken depending on the geographical location and environment of the facility:

- Unnecessary electrical equipment and appliances should be turned off in the event that power restoration would surge causing damage to electronics and affecting sensitive equipment.
- Facilities with freezing temperatures should turn off and drain the following lines in the event of a long term power loss.
  - Fire sprinkler system
  - Standpipes
  - Potable water lines
  - Toilets
- Add propylene-glycol to drains to prevent traps from freezing
- Equipment that contain fluids that may freeze due to long term exposure to freezing temperatures should be moved to heated areas, drained of liquids, or provided with auxiliary heat sources.

Upon Restoration of heat and power:
- Electronic equipment should be brought up to ambient temperatures before energizing to prevent condensate from forming on circuitry.
- Fire and potable water piping should be checked for leaks from freeze damage after the heat has been restored to the facility and water turned back on.
When an EMERGENCY has been declared at the BASEBALL FIELD and an ambulance is needed during an athletic event, the following protocol should be followed as closely as possible.

9. **On Field Evaluation:**
   - **Certified Athletic Trainer:** Randy Wilkes
   - Assisted by Student Athletic Trainer (SAT)
   - Retrieval of splints, ice bags, etc.

10. **Call 911**
    - **Head Coach:**
      - Use athletic trainer’s cell phone
      - Location: The baseball field is located to the left of the front of the school building.
      - Ambulance Directions: The ambulance will enter the main entrance to the school and turn right on the frontage road that goes in front of the school. This road will take them all the way to the baseball field.
      - Provide pertinent information to dispatcher

11. **Team Control**
    - **Assistant Coach:** Direct athletes away from injured player

12. **Crowd Control**
    - **Assistant Coach:** Keep crowd off field

13. **Contact Parents**
    - **Athletic Trainer/Head Coach:**
      - In life threatening situation, call parents (phone numbers with the head coach)
      - In non life-threatening situation, let the athlete call home

14. **Contact Team Physician**
    - **Certified Athletic Trainer:** Randy Wilkes
      - Call to inform the physician of the situation

15. **Direct Paramedics**
    - **Assistant Coach:**
      - Stand outside of the field on the road to flag down EMTs.

16. **Hospital**
    - **GA/SAT and/or Parents:**
      - Call on duty ATC ASAP with medical status

*If no ambulance is needed: SAT/GA or parent to drive. Call on duty ATC ASAP*
EMERGENCY CARE PLAN
Baseball Field

Procedures for Activating Emergency Plan

1. In the event of an injury to a student-athlete, the athletic trainer or certified first-aider should assess the extent of the injury. Always remember to wait until the official stops the game and do not move athlete until responsiveness and degree of injury are assessed.

2. If a certified first-aider feels the need for assistance they should contact the Certified Athletic Trainer if he/she is not present. The student athletic trainer and first-aider may assist in minor wound bandaging, ice bagging, and simple First Aid procedures; they can also make the necessary communications for other needed services.

3. When a situation is deemed life threatening (head, neck, or back injury or cardiac pathology) or serious in nature, one person should immediately activate EMS by the phone. The same person will instruct an assistant to clear the area located closest to the road in which the injured athlete is lying. Someone should stand outside of the field on the road to flag down EMTs and instruct the ambulance where to go. Make sure that the area is clear and the ambulance will have plenty of space.

4. Once the ambulance arrives, EMTs will have complete control of the scene and the situation. If transporting a student-athlete is necessary an athletic trainer or designated person should go to the hospital to provide necessary information.

Directions to the Baseball Field

The baseball field is located to the left of the front of the school building. Direct the ambulance to enter the main entrance to the school and turn right on the frontage road that goes in front of the school.
When an **EMERGENCY** has been declared at the **SOFTBALL FIELD** and an ambulance is needed during an athletic event, the following protocol should be followed as closely as possible.

1. **On Field Evaluation:**  
   **Certified Athletic Trainer:** Randy Wilkes  
   **Assisted by Student Athletic Trainer (SAT):**  
   Retrieval of splints, ice bags, etc.

2. **Call 911**  
   **Head Coach:**  
   - Use athletic trainer’s cell phone  
   - **Location:** The softball field is located directly in front of the front of the school building, past the football field. It is on Mountain View Road one street northeast of the main entrance to the school.  
   - **Ambulance Directions:** The ambulance will pull into the parking lot entrance on Mountain View Road, which is just past the main entrance to the school. This parking lot provides access to the softball field.  
   - Provide pertinent information to dispatcher

3. **Team Control**  
   **Assistant Coach:**  
   Direct athletes away from injured player

4. **Crowd Control**  
   **Assistant Coach:** Keep crowd off field

5. **Contact Parents**  
   **Athletic Trainer/Head Coach:**  
   - In life threatening situation, call parents (phone numbers with the head coach)  
   - In non life-threatening situation, let the athlete call home

6. **Contact Team Physician**  
   **Certified Athletic Trainer:** Randy Wilkes  
   Call to inform the physician of the situation

7. **Direct Paramedics**  
   **Assistant Coach:**  
   Stand in the parking lot to flag down EMTs.

8. **Hospital**  
   **GA/SAT and/or Parents:**  
   - Call on duty ATC ASAP with medical status

*If no ambulance is needed: SAT/GA or parent to drive. Call on duty ATC ASAP*
EMERGENCY CARE PLAN
Softball Field

Procedures for Activating Emergency Plan

1. In the event of an injury to a student-athlete, the athletic trainer or certified first-aider should assess the extent of the injury. Always remember to wait until the official stops the game and do not move athlete until responsiveness and degree of injury are assessed.

2. If a certified first-aider feels the need for assistance they should contact the Certified Athletic Trainer if he/she is not present. The student athletic trainer and first-aider may assist in minor wound bandaging, ice bagging, and simple First Aid procedures; they can also make the necessary communications for other needed services.

3. When a situation is deemed life threatening (head, neck, or back injury or cardiac pathology) or serious in nature, one person should immediately activate EMS by the phone. The same person will instruct an assistant to clear the area located closest to the road in which the injured athlete is lying. Someone should wait in the parking lot to flag down and instruct the ambulance where to go. Make sure that the area is clear and the ambulance will have plenty of space.

4. Once the ambulance arrives, EMTs will have complete control of the scene and the situation. If transporting a student-athlete is necessary an athletic trainer or designated person should go to the hospital to provide necessary information.

Directions to the Softball Field

The softball field is located in front of the front of the school building past the football field. It is on Mountain View Road one street northeast of the main entrance to the school. Direct the ambulance to the correct parking lot.
When an **EMERGENCY** has been declared at the **FOOTBALL GAME FIELD** and an ambulance is needed during an athletic event, the following protocol should be followed as closely as possible.

1. **On Field Evaluation:**  
   Certified Athletic Trainer: Randy Wilkes  
   Assisted by Student Athletic Trainer (SAT)  
   Retrieval of splints, ice bags, etc.

2. **Call 911**  
   **Head Coach:**  
   - Use athletic trainer’s cell phone  
   - Location: The football game field is located directly in front of the front of the school building.  
   - Ambulance Directions: The ambulance will enter through the main entrance (Mountain View Road entrance) and immediately turn right into the field access gate. This will allow them to pull all the way up to the field.  
   - Provide pertinent information to dispatcher

3. **Team Control**  
   **Assistant Coach:**  
   Direct athletes away from injured player

4. **Crowd Control**  
   **Police:** Keep crowd off field

5. **Contact Parents**  
   **Athletic Trainer/Head Coach:**  
   - In life threatening situation, call parents (phone numbers in medical kit)  
   - In non life-threatening situation, let the athlete call home

6. **Contact Team Physician**  
   Certified Athletic Trainer: Randy Wilkes  
   - Call to inform the physician of the situation

7. **Direct Paramedics**  
   **Police:**  
   Stand at the field access gate to flag down EMTs and make sure the gate is open.

8. **Hospital**  
   GA/SAT and/or Parents:  
   - Call on duty ATC ASAP with medical status

*If no ambulance is needed: SAT/GA or parent to drive. Call on duty ATC ASAP*
EMERGENCY CARE PLAN
Football Game Field

Procedures for Activating Emergency Plan

1. In the event of an injury to a student-athlete, the athletic trainer or certified first-aider should assess the extent of the injury. Always remember to wait until the official stops the game and do not move athlete until responsiveness and degree of injury are assessed.

2. If a certified first-aider feels the need for assistance they should contact the Certified Athletic Trainer if he/she is not present. The student athletic trainer and first-aider may assist in minor wound bandaging, ice bagging, and simple First Aid procedures; they can also make the necessary communications for other needed services.

3. When a situation is deemed life threatening (head, neck, or back injury or cardiac pathology) or serious in nature, one person should immediately activate EMS by the phone. The same person will instruct an assistant to clear the area located closest to the road in which the injured athlete is lying. Someone should wait at the field access gate to flag down and instruct the ambulance where to go. Make sure that the area is clear and the ambulance will have plenty of space.

4. Once the ambulance arrives, EMTs will have complete control of the scene and the situation. If transporting a student-athlete is necessary an athletic trainer or designated person should go to the hospital to provide necessary information.

Directions to the Football Game Field

The football game field is located directly in front of the front of the school building. Direct the ambulance to the field access gate and make sure the gate is unlocked and opened.
When an **EMERGENCY** has been declared at the **FOOTBALL PRACTICE FIELD** and an ambulance is needed during an athletic event, the following protocol should be followed as closely as possible.

1. **On Field Evaluation:**
   - **Certified Athletic Trainer:** Randy Wilkes
   - Assisted by **Student Athletic Trainer (SAT)**
   - Retrieval of splints, ice bags, etc.

2. **Call 911**
   - **Head Coach:**
     - Use athletic trainer’s cell phone
     - **Location:** The football practice field is located on the corner of County Highway 1145 and Amos Road. This is in front and slightly to the left of the front of the school building.
     - **Ambulance Directions:** The ambulance will pull into the parking lot entrance on Mountain View Road, which is just past the main entrance to the school. There is access to the practice field from this parking lot.
     - Provide pertinent information to dispatcher

3. **Team Control**
   - **Assistant Coach:**
     - Direct athletes away from injured player

4. **Crowd Control**
   - **Assistant Coach:** Keep crowd off field

5. **Contact Parents**
   - **Athletic Trainer/Head Coach:**
     - In life threatening situation, call parents (phone numbers with the head coach)
     - In non life-threatening situation, let the athlete call home

6. **Contact Team Physician**
   - **Certified Athletic Trainer:** Randy Wilkes
     - Call to inform the physician of the situation

7. **Direct Paramedics**
   - **Assistant Coach:**
     - Stand in the parking lot to flag down EMTs.

8. **Hospital**
   - **GA/SAT and/or Parents:**
     - Call on duty ATC ASAP with medical status

*If no ambulance is needed: SAT/GA or parent to drive. Call on duty ATC ASAP*
EMERGENCY CARE PLAN
Football Practice Field

Procedures for Activating Emergency Plan

1. In the event of an injury to a student-athlete, the athletic trainer or certified first-aider should assess the extent of the injury. Always remember to wait until the official stops the game and do not move athlete until responsiveness and degree of injury are assessed.

2. If a certified first-aider feels the need for assistance they should contact the Certified Athletic Trainer if he/she is not present. The student athletic trainer and first-aider may assist in minor wound bandaging, ice bagging, and simple First Aid procedures; they can also make the necessary communications for other needed services.

3. When a situation is deemed life threatening (head, neck, or back injury or cardiac pathology) or serious in nature, one person should immediately activate EMS by the phone. The same person will instruct an assistant to clear the area located closest to the road in which the injured athlete is lying. Someone should wait in the parking lot to flag down and instruct the ambulance where to go. Make sure that the area is clear and the ambulance will have plenty of space.

4. Once the ambulance arrives, EMTs will have complete control of the scene and the situation. If transporting a student-athlete is necessary an athletic trainer or designated person should go to the hospital to provide necessary information.

Directions to the Football Practice Field

The football practice field is located on the corner of County Highway 1145 and Amos Road. This is in front and slightly to the left of the front of the school building. Direct the ambulance to the parking lot entrance on Mountain View Road, which is just past the main entrance to the school.
When an **EMERGENCY** has been declared at the **GYMNASIUM** and an ambulance is needed during an athletic event, the following protocol should be followed as closely as possible.

1. **On Field Evaluation:**
   - **Certified Athletic Trainer:** Randy Wilkes
   - **Assisted by Student Athletic Trainer (SAT):**
   - Retrieval of splints, ice bags, etc.

2. **Call 911**
   - **Head Coach:**
     - Use athletic trainer’s cell phone
     - Location: The gymnasium is attached to the left side of the school building.
     - Ambulance Directions: The ambulance should enter through the main entrance to the school and proceed around to the back of the school. There is ramp access between the two gyms where the ambulance can pull in between the two buildings.
     - Provide pertinent information to dispatcher

3. **Team Control**
   - **Assistant Coach:**
     Direct athletes away from injured player

4. **Crowd Control**
   - **Police:** Keep crowd off court

5. **Contact Parents**
   - **Athletic Trainer/Head Coach:**
     - In life threatening situation, call parents (phone numbers with the head coach)
     - In non life-threatening situation, let the athlete call home

6. **Contact Team Physician**
   - **Certified Athletic Trainer:** Randy Wilkes
     - Call to inform the physician of the situation

7. **Direct Paramedics**
   - **Police:**
     Stand at the ramp access between the two gyms to flag down EMTs and make sure gym doors are open.

8. **Hospital**
   - **GA/SAT and/or Parents:**
     - Call on duty ATC ASAP with medical status

*If no ambulance is needed: SAT/GA or parent to drive. Call on duty ATC ASAP*
EMERGENCY CARE PLAN
Gymnasium

Procedures for Activating Emergency Plan

1. In the event of an injury to a student-athlete, the athletic trainer or certified first-aider should assess the extent of the injury. Always remember to wait until the official stops the game and do not move athlete until responsiveness and degree of injury are assessed.

2. If a certified first-aider feels the need for assistance they should contact the Certified Athletic Trainer if he/she is not present. The student athletic trainer and first-aider may assist in minor wound bandaging, ice bagging, and simple First Aid procedures; they can also make the necessary communications for other needed services.

3. When a situation is deemed life threatening (head, neck, or back injury or cardiac pathology) or serious in nature, one person should immediately activate EMS by the phone. The same person will instruct an assistant to clear the area located closest to the road in which the injured athlete is lying. Someone should wait at the ramp access between the two gyms to flag down and instruct the ambulance where to go. Make sure that the area is clear and the ambulance will have plenty of space.

4. Once the ambulance arrives, EMTs will have complete control of the scene and the situation. If transporting a student-athlete is necessary an athletic trainer or designated person should go to the hospital to provide necessary information.

Directions to the Gymnasium

The gymnasium is attached to the left side of the school building. Direct the ambulance to the ramp access between the two gyms and make sure the gym doors are unlocked and opened.
When an **EMERGENCY** has been declared at the **TENNIS COURTS** and an ambulance is needed during an athletic event, the following protocol should be followed as closely as possible.

9. **On Field Evaluation:**
   - Certified Athletic Trainer: Randy Wilkes
   - Assisted by Student Athletic Trainer (SAT)
   - Retrieval of splints, ice bags, etc.

10. **Call 911**
    - **Head Coach:**
      - Use athletic trainer’s cell phone
      - Location: The tennis courts are located in front of the front of the school building. From the entrance of the school building, the tennis courts are located immediately on the right.
      - Ambulance Directions: The ambulance will pull into the tennis court parking lot on the right as they turn into the main entrance before they go through the gates.
      - Provide pertinent information to dispatcher

11. **Team Control**
    - **Assistant Coach:**
      - Direct athletes away from injured player

12. **Crowd Control**
    - **Police:** Keep crowd off court

13. **Contact Parents**
    - **Athletic Trainer/Head Coach:**
      - In life threatening situation, call parents (phone numbers with the head coach)
      - In non life-threatening situation, let the athlete call home

14. **Contact Team Physician**
    - **Certified Athletic Trainer:** Randy Wilkes
      - Call to inform the physician of the situation

15. **Direct Paramedics**
    - **Police:** Stand in the parking lot to flag down EMTs.

16. **Hospital**
    - **GA/SAT and/or Parents:**
      - Call on duty ATC ASAP with medical status

*If no ambulance is needed: SAT/GA or parent to drive. Call on duty ATC ASAP*
EMERGENCY CARE PLAN
Tennis Courts

Procedures for Activating Emergency Plan

5. In the event of an injury to a student-athlete, the athletic trainer or certified first-aider should assess the extent of the injury. Always remember to wait until the official stops the game and do not move athlete until responsiveness and degree of injury are assessed.

6. If a certified first-aider feels the need for assistance they should contact the Certified Athletic Trainer if he/she is not present. The student athletic trainer and first-aider may assist in minor wound bandaging, ice bagging, and simple First Aid procedures; they can also make the necessary communications for other needed services.

7. When a situation is deemed life threatening (head, neck, or back injury or cardiac pathology) or serious in nature, one person should immediately activate EMS by the phone. The same person will instruct an assistant to clear the area located closest to the road in which the injured athlete is lying. Someone should wait in the parking lot to flag down and instruct the ambulance where to go. Make sure that the area is clear and the ambulance will have plenty of space.

8. Once the ambulance arrives, EMTs will have complete control of the scene and the situation. If transporting a student-athlete is necessary an athletic trainer or designated person should go to the hospital to provide necessary information.

Directions to the Tennis Courts

The tennis courts are located in front of the front of the school building. From the entrance of the school building, the tennis courts are located immediately on the right. Direct the ambulance to the tennis court parking lot.

Ootlewah’s campus diagram is provided on the following page concerning these athletic sites.
- Green Rectangle indicates the athletic training room location.

- Red dots indicate the location of the ambulance entrance to each athletic facility and in the event of an emergency, paramedics should be directed to these specific locations for optimal efficiency.
When an EMERGENCY has been declared at the BASEBALL FIELD and an ambulance is needed during an athletic event the following protocol should be followed as closely as possible.

1. On Field Evaluation: Certified Athletic Trainer: assisted by Student Athletic Trainer (if applicable) with retrieval of splints, ice bags, etc.
2. Head Coach: Mike Policastro- CALL 911
   - Use athletic trainer's cell phone or phone in Athletic Training room
   - Location: On Akisson Drive between gymnasium and softball field
   - Ambulance access through large gate by corner of the outfield on 1" base line
   - Provide pertinent information to dispatcher (location, condition, symptoms, etc.)
3. Team Control Assistant Coach: Andy Lockhart
   - Direct athletes away from injured player
4. Crowd Control Campus Police: Keep crowd off field
   - Athletic Director/assistant coach: Keep relatives off field, but aware of situation
5. Contact Parents Assistant: Aaron Bryant
   - In life threatening situation call parents
   - In non life-threatening situation let the athlete call home
6. Contact Team Physician (if applicable)/Athletic Trainer
   Supervising Athletic Trainer: Jessie Carney (423-920-3768)
7. Direct Paramedics Campus Police:
   Stand at parking lot entrance between Quinton Lane Gymnasium and the tennis courts on Adkisson Drive and wave down emergency responders instructing them on where to go. Keep path clear to 1st base line gate.

If no ambulance is needed: friend or parent to drive. Call on duty ATC ASAP
EMERGENCY CARE PLAN

Baseball Field
Initiate 911 first, and then dial 423-618-1720 (Campus Police) for on-campus emergencies

Procedures for Activating Emergency Plan
1. In the event of an injury to a student-athlete, the athletic trainer or certified first- aider should assess the extent of the injury. Always remember to wait until the official stops the game and do not move athlete until responsiveness and degree of injury are assessed.

2. If a certified first-aider feels the need for assistance they should contact the Certified Athletic Trainer if he/she is not present. The first-aider may assist in minor wound bandaging, ice bagging, and simple First Aid procedures; they can also make the necessary communications for other needed services.

3. When a situation is deemed life threatening (head, neck, or back injury or cardiac pathology) or serious in nature, one person should immediately activate EMS by the phone. The same person will instruct an assistant to clear the area located closest to the road in which the injured athlete is lying. Someone should wait 1st base line drive way at the gate on the Adkisson Drive parking lot between the gym and the tennis courts to flag down and instruct the ambulance where to go. Make sure that the area is clear and the ambulance will have plenty of space.

4. Once the ambulance arrives, EMTs will have complete control of the scene and the situation. If transporting a student-athlete is necessary an athletic trainer or designated person should go to the hospital to provide necessary information.

Direction to Baseball Field
The Baseball field is located on Adkisson Drive between the Quinton Lane Gymnasium and the softball field. Someone should be standing in the parking lot between the gymnasium and the tennis courts to lead emergency personnel through the 5 base line outfield gate.
Cleveland State Emergency Management

Treatment of Diabetes

Diabetes, or otherwise called diabetes mellitus, is a disease effecting a person's blood sugar level. This may occur due to inadequate insulin production or the body's inability to react correctly to that insulin. Many diabetics have had the condition for an extended time and are self-regulating regarding their condition. A diabetic may have various conditions related to their blood sugar level including mild to moderate hypoglycemia, severe hypoglycemia, and hyperglycemia. Acceptable blood sugar levels are 70-100 milligrams per deciliter. Any levels above or below this norm is considered hypoglycemic or hyperglycemic, respectively. Each condition requires different treatment and varies in seriousness.

Mild to Moderate Hypoglycemia:

Mild hypoglycemia occurs when the blood sugar level is low. This condition needs to be treated quickly before it escalates and the blood sugar level continues to drop.

SIGNS AND SYMPTOMS:

a. Behavioral changes such as: acting quiet/withdrawn, stubborn or restlessness, tantrums of sudden rage, confusion, inappropriate emotional responses, poor concentration or daydreaming
b. shakiness
c. excessive sweating
d. headache
e. dizziness
f. increased heart rate
g. loss of balance
h. slurred speech
i. blank stare

Treatment of hypoglycemia is to raise the blood sugar level back to a healthy range. This can be done in a few ways: glucose tablets, fruit juice, soda, milk, or liquid glucose found in many first aid kits. After giving out the glucose wait 15-20 minutes and recheck the blood sugar if you are able. Once the blood sugar level reaches at least 70 milligrams per deciliter, they will be considered back to "normal" range, although blood sugar levels vary among individuals.

Severe Hypoglycemia:

In the instance that a blood sugar level dips to dangerous measurements (as low as 20 in some cases) symptoms will escalate. This is an EMERGENCY. Call 911 immediately. Be sure the person is lying on their side in a safe area. Note any loss of consciousness.
SIGNS AND SYMPTOMS:

a. Loss of consciousness  
b. Unresponsiveness  
c. Convulsion-like movements  
d. Failure to respond to attempts to increase blood sugar level

Hyperglycemia:

This condition occurs when blood glucose levels are excessively high. Although this is not always an emergency, blood glucose over 240 mg/dl will require notification of a physician and checking the urine for ketones.

SIGNS AND SYMPTOMS:

a. Loss of appetite  
b. Increased thirst  
c. Frequent urination  
d. Tiredness, sleepiness  
e. Inattentiveness  
f. Rapid breathing  
g. Fruity odor to the breath  
h. Blurred vision

If the person is not diagnosed previously with diabetes and is experiencing these symptoms they may have the condition and not be aware of it. They should contact their physician as soon as possible.
Athletic Training
Policies & Procedures

Grace Baptist Academy
Mission Statement
The Certified Athletic Trainer (AT) seeks to provide a safe environment for the student-athletes, not only physically, but also mentally, emotionally, and spiritually. The AT will provide quality medical care in the fields of injury prevention, recognition, management, evaluation, treatment and rehabilitation for athletic injuries sustained by Grace Baptist Academy student-athletes. Working in conjunction with the Sports Medicine Team, the Certified Athletic Trainer will return student-athletes to play as safely and quickly as possible.

Standards of Ethical Conduct

The goal of the Athletic Trainer is to create an atmosphere in which the athlete feels safe physically, mentally, emotionally, and spiritually. Adherence to the National Athletic Trainers' Association Code of Ethics promotes these ideals and helps the athletic trainer maintain the level of professionalism necessary to deliver quality medical care. (Appendix A)

Principle 1: The athletic trainer shall respect the rights, dignity and welfare of all.

Principle 2: The athletic trainer shall comply with the laws and regulations governing the practice of athletic training. (Appendix B)

Principle 3: The athletic trainer shall maintain and promote high standards in their provision of services

Principle 4: The athletic trainer shall not engage in conduct that could be construed as a conflict of interest or that reflects negatively on the profession.

Sports Medicine Team
The Sports Medicine Team includes health care professionals and allied healthcare professionals, as well as the student-athlete, school administrators, coaches, parents, participants, and bystanders. These health care professionals could include, but are not limited to: certified athletic trainers, team physicians, consulting physicians, school nurses, physical therapists, emergency medical services personnel, dentists and other allied health care professionals. Of these, the athlete will have the most contact with the athletic trainer, school nurse, team physician, and coach.

Sports Medicine Team Defined
Certified Athletic Trainer (CAT): An allied health professional that has completed an accredited postsecondary curriculum, obtained certification from the National Athletic Trainers' Association Board of Certification (NATABOC), and is currently licensed in good standing with the state of Tennessee. He/she has specialized training in prevention, recognition, management, evaluation, treatment and rehabilitation of athletic injuries. The AT must also maintain certification in CPR, First Aid, and Blood Bourne pathogens. (T.C.A. 63-24-101)
Team Physician: A medical doctor (M.D.) or doctor of osteopathy (D.O.) who has an unrestricted medical license in good standing with the state of Tennessee. He/she preferably is an orthopedic surgeon or has completed a Sports Medicine Fellowship and has a working knowledge of trauma, musculoskeletal injuries, as well as other various medical conditions that affect athletes. The team physician should integrate medical expertise from other health care providers, including ATs, medical specialists, or other allied health professionals. He/she must ultimately assume responsibility for medical decisions made by the defined Sports Medicine Team surrounding an athlete's medical condition.

Consulting Physician: A licensed physician currently in good standing with the Medical Board of Tennessee. The consulting physician may use in lieu of the team physician in the case of a scheduling conflict on behalf of the team physician. In addition, the team physician may refer an athlete to physician with a specialty if he/she feels the consulting physician has more expertise with that injury. Lastly, a consulting physician may be a physician acting out of good faith during an athletic event.

Job Descriptions
Athletic Trainer:
- Attempt to prevent injuries through
  - Use of Pre-Participation Examinations (PPE)
  - Monitoring field/court/track conditions
  - Monitoring equipment conditions
  - Monitoring weather conditions
- Evaluation of injuries according to physician protocol
- Management of injuries according to physician protocol, including:
  - Basic first aid for all injuries
  - Basic life support (CPR, AED, etc.) for life threatening situations
  - Taping, wrapping, bandaging, padding, splinting athletic injuries
- Referral of athletic injuries as needed
- Administration of treatments according to physician protocol
- Development of rehabilitation programs based on physician protocol
- Coverage of home athletic events
- Supervising upkeep of medical records
- Communicate with coaches/nurses/parents/teachers about injured players
- Establish athletic training room procedures
- Monitor Athletic Training budget - appropriations and expenditures
  - Inventory athletic training supplies
  - Purchase athletic training room supplies
• Place bid in the spring for supplies needed for the following year
• Purchase and maintain athletic training equipment
• Maintain cleanliness of athletic training facility

Team Physician/Consulting Physician
• Be available through appointment for student-athletes at Grace Baptist Academy
• Be present or available for as many home games as possible to oversee any emergency situation that requires a physician
• Make return to play decisions for student-athletes under the direct care of the team physician

Coach
• Assist AT during an emergency situation
• Inform AT of any injury/illness incurred while the AT was not present

Medical Eligibility
Any student-athlete that does not have the appropriate paperwork will not be allowed to participate. He/she will be considered medically ineligible as per Tennessee Secondary School Athletic Association (TSSAA) regulations. All coaches should submit a full roster to the athletic trainer prior to the start of the athletic season.

Pre-Participation Examination: In accordance with the TSSAA Constitution, Article II, Section 10, student-athletes must have a pre-participation physical not prior to April 15th for the following school year (Appendix D). Such a physical must be performed by a D.O., M.D., physician's assistant or certified nurse practitioner and state that the student is physically fit to participate in interscholastic athletics. No student-athlete will be allowed to participate in athletics, including practices, until either a physical form, or a letter signed by the parents stating such a physical is against practices or beliefs, is turned in to the athletic trainer. (Appendix E)

Medical History Form: Each student-athlete will be required to fill out a medical history form. The information on this form will be used in the case of emergency (i.e. allergic reactions to certain medications), or to help during the evaluation of an injury and/or condition. It will not be used for any other purpose and will be seen only by the necessary medical personnel as per the Health Information Portability and Accountability Act regulations. This may be included with the PPE form. (Appendix E)

Emergency Contact Information: All student-athletes will be required to turn in an emergency contact information form to the athletic trainer prior to the involvement in any athletic event. Such information will include the phone numbers (cell, work, and home) of the primary person to contact in the event of an emergency, as well as a secondary person to contact in case the primary cannot be reached. (Appendix E)

Consent to Treat and Assumption of Risk: Each student-athlete will be required to turn a form, signed by both the student-athlete and his/her parents/legal guardians, that gives the athletic trainer, team physicians, and emergency personnel the right to treat the student-athlete in the absence of the parents/legal guardians. This gives the athletic trainer the right to evaluate, treat, and make the appropriate medical decisions the student-athlete during practices and/or games. Student-athletes and their parents/guardians must also sign an
assumption of risk form. This form acknowledges that sports participation can be dangerous, and in the most extreme circumstances, deadly, and releases Grace Baptist Academy and the medical staff from liability due to athletic participation. (Appendix E: on emergency contact form)

Health Information Portability and Accountability Act (HIPAA): Part of HIPAA is designed to protect personal medical information from being released without the consent of the patient. Thus, it is the responsibility of the athletic trainer to maintain the integrity of each student-athlete's medical information. However, to ensure that student-athlete receives the best medical care possible, it is occasionally necessary to share medical information with other doctors, EMS personnel, etc. In accordance with HIPAA, the athletic trainer "must make a reasonable effort to disclose only the minimum necessary information required" to make appropriate medical decisions. A letter explaining the importance of HIPAA will be given to the student-athletes for them and their parents/guardians, as well as a form that must be signed by the student-athlete and the parents/guardians allowing the athletic trainer to share pertinent medical information with the appropriate medical personnel. (See Appendix E)

Athletic Training Services

Location: The Athletic Training Room (ATR) is located in the high school building. It is across from the gym in the coaches' office.

Hours: During the regular school year the athletic training room will be open weekdays after school until the end of practices or games. In addition, the ATR is open on the weekends for games and practices on an as needed basis. Hours are posted on the athletic training room door. Hours are as follows:

Monday - Friday: 3:00 PM to 15 minutes after the last practice during games (based on sport/season priority)

The athletic trainer will be in the athletic training room from 3:00 pm until 4:15 pm (roughly the start of practice). Once practice starts the athletic training room will be locked and the athletic trainer will be at the practice that receives highest priority or in a centralized and visible location.
Priority Coverage of Athletic Events: Priority coverage of sporting events is based on a number of different factors. As a rule of thumb, priority will be as follows:

In-Season has priority over Out-of-Season Sports Home events have priority over away events
Games have priority over scrimmages; Scrimmages over practices

When multiple sporting events are at the same time, priority is based on type of sport and injury rate. Sport priorities are ranked highest to lowest as follows:
Contact Sports:
Contact/Collision Sports: Football, Soccer
Limited Contact/Impact: Baseball, Basketball, Softball, Volleyball Non-Contact Sports:
Strenuous: Cross Country/Track Moderately Strenuous: Tennis Non-Strenuous: Golf

When multiple sports in the same category are practicing or have games at the same time, determination of priority is based on the likelihood of injury according a study conducted by the Center of Disease Control (See Table). The sport with the highest rate of injury will receive priority coverage.

TABLE. Sport-specific Injury rates*In practice, competition, and overall - High School Sports-Related Injury Surveillance Study, United States, 2005-06 school year

<table>
<thead>
<tr>
<th>Sport</th>
<th>Practice</th>
<th>Competition</th>
<th>overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys' football</td>
<td>2.54</td>
<td>12.09</td>
<td>4.36</td>
</tr>
<tr>
<td>Boys' wrestling</td>
<td>2.04</td>
<td>3.93</td>
<td>2.50</td>
</tr>
<tr>
<td>Boys' soccer</td>
<td>1.58</td>
<td>4.22</td>
<td>2.43</td>
</tr>
<tr>
<td>Girls' soccer</td>
<td>1.10</td>
<td>5.21</td>
<td>2.36</td>
</tr>
<tr>
<td>Girls' basketball</td>
<td>1.37</td>
<td>3.60</td>
<td>2.01</td>
</tr>
<tr>
<td>Boys' basketball</td>
<td>1.46</td>
<td>2.98</td>
<td>1.89</td>
</tr>
<tr>
<td>Girls' volleyball</td>
<td>1.48</td>
<td>1.92</td>
<td>1.64</td>
</tr>
<tr>
<td>Boys' baseball</td>
<td>0.87</td>
<td>1.77</td>
<td>1.1Q</td>
</tr>
<tr>
<td>Girls' softball</td>
<td>0.7Q</td>
<td>1.78</td>
<td>1.13</td>
</tr>
<tr>
<td>Total</td>
<td>1.69</td>
<td>4.63</td>
<td>2.44</td>
</tr>
</tbody>
</table>

* Per 1,000 athlete exposures O.e., practices or competitions).
(http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5538ai.htm#tab)

Athletic Training Room Rules:
1. Supplies are for medical use only
2. No shoes in the ATR
3. No bags/equipment allowed in ATR
4. No food or drinks allowed in ATR (water bottles permitted)
5. If you get something out, put it back!
6. No Loitering
7. Do not put anything on the table
Protocol for Injury Evaluation (Cat practice/game): If an athlete is injured, the athletic trainer will be summoned if he/she is not already present. At that time the evaluation will proceed as follows:

1. Assess for life threatening injuries in the following order
   a. Breathing
   b. Pulse
   c. Excessive bleeding/Exposed bones
   d. Spinal column/cord trauma
   e. Concussion assessment

2. Assess for injuries requiring emergency care
   a. Dislocated joints
   b. Broken bones
   c. Extremity neurovascular trauma
   d. Gaping wounds
   e. Eye trauma
   f. Oral trauma
   g. Abdominal Injuries

3. Assess for injuries requiring immediate care
   a. Muscle cramping (due to dehydration, this may escalate to an emergency situation depending on severity and duration)
   b. Muscle strains/tears
   c. Ligament sprains/tears
   d. Contusions
   e. Minor wounds

4. At the end of the evaluation, the AT will begin initial treatment/management of injury (see Initial Treatment Protocol)
   a. Document on injury evaluation form and file with the athlete's medical records (Appendix F).

If the injury happens on the field (court/track/course) during a game (match/meet), the athlete will be removed from the field once it has been established by the medical personnel that the athlete can be moved without causing further injury. Although done as quickly as possible, the athletic trainer will take the time necessary to ensure that the athlete incurs no further injury. Under no circumstances should anyone move the athlete without the athletic trainer's or a doctor's consent.

Primacy Injury Assessment (Life Threatening):
Upon arrival at the scene, the athletic trainer will conduct a primary assessment:

1. Check athlete for consciousness
   a. If the athlete is conscious, the AT will begin secondary assessment
   b. If the athlete is unconscious, the AT will continue primary assessment
2. Check athlete's ABCs (airway, breathing, circulation)
   a. Log roll the athlete*
   b. If the athlete is not breathing, the AT will begin mouth-to-mouth resuscitation**, check pulse, and instruct the coach to retrieve AED and signal to Game Administrator to call 911
      i. If the athlete has a pulse, the AT will continue mouth-to-mouth until EMS arrives
   n. If the athlete doesn't have a pulse, the AT will begin CPR as the coach prepares the athlete for the AED/CPR
      1. The AED will assess for a shockable rhythm.
         a. If no such rhythm exists, the AT will start/continue CPR until EMS arrives
         b. If there is a shockable rhythm, the AT will follow the instructions provided by the AED
   m. If the athlete regains a rhythm and starts to breathe on his/her own, the AT will continue to monitor the athlete until EMS arrives
      c. If the athlete is breathing, the AT will begin secondary assessment

Secondary Assessment (possible life threatening injuries): Upon arrival the athlete is conscious and breathing:

1. Check athlete for excessive bleeding (Follow Universal Precautions)
   a. Look for any exposed bones
   b. Apply direct pressure if the AT doesn't suspect a fracture/break, or apply pressure to nearest artery pulse point in the event of exposed bones and instruct coach to call 911
   c. Elevate injured area (if no fracture/break/exposed bones)
   d. Apply tourniquet if bleeding doesn't stop
2. Check athlete for cervical spine injury (at any point there is a positive sign for cervical spine injury the evaluation stops, the AT will stabilize and instruct the coach to call 911)
   a. Look for neck deformities, strange head positions
   b. Ask athlete about sensations (pain, pins and needles, any snaps/pops/cracks heard)
   c. Palpate cervical area (looking for crepitus, point tenderness, increase in symptoms, bilateral neck musculature spasm)
   d. Test sensations bilaterally in upper and lower extremities (have athlete wiggle fingers/toes, squeeze legs/arms)
   e. Perform neurological tests
3. Check the athlete for a concussion
   a. Determine level of consciousness
   b. Determine cause of injury (i.e. blow to head)
   c. Look for any bumps, cuts, wounds
   d. Perform cranial nerve tests
   e. Perform cognition tests
   f. Refer if necessary
g. If not immediately referred, repeat tests every 5 minutes
h. The AT will call 911 if symptoms worsen

I. If symptoms are stable and the athlete is deemed safe to go home, the AT will send a Head Injury Care Form home with athlete. Form outlines necessary steps for parents to take to ensure proper care for the athlete. (Appendix G)
n. AT will record evaluation on the Injury Evaluation form (Appendix F)
   1. If symptoms do not worsen and the athlete remains stable, the AT will perform a follow-up evaluation the following day.
      i. Follow-up evaluations are recorded on the Concussion Follow-up Form (Appendix H)

11. The athlete will not be released for activity until one or both of the following conditions are met
   1. A medical doctor releases the athlete after evaluating the athlete for a concussion
   2. The athlete successfully completes the return to play protocol for concussions under supervision of the AT (Appendix M)

* The AT will only perform a log roll under the following conditions:
  1. The athlete is prone and not breathing
  2. The athlete is prone and the AT can’t determine if he/she is breathing
     3. The athlete is a football player. Athlete will be log rolled if prone and face mask removed should the athlete go into shock
     4. EMS has arrived and the athlete needs to be spine boarded

**In the case of sports with a helmet and facemask, the facemask will be removed to allow AT to perform mouth-to-mouth resuscitation. For football, the helmet WILL NOT be removed unless the facemask cannot be removed in a timely manner. Football helmets and shoulder pads should not be removed until a cervical spine injury has been ruled out unless absolutely necessary to administer mouth-to-mouth and/or CPR.

General Injury Protocol (injuries requiring emergency or immediate care) upon arrival (either the athlete to the training room or the AT to the field), the AT rules out life threatening conditions:
1. If entering the Athletic Training Room, the athlete must sign in at front desk (Appendix I)
2. Obtain history: determine mechanism of injury (MOI), location of pain, abnormal sensations, associated sounds, and previous history of injury to that area. If the athlete is unable to provide history, witnesses can be questioned at the appropriate time.
   3. Observation: AT will look for visible deformities, bleeding, swelling, and discoloration.
      a. If a cervical spine injury is suspected, appropriate tests will be conducted. AT will call EMS if cervical spine cannot be cleared.
b. If a deformity is present, the AT will splint the area and refer for emergency care.

4. Palpation: AT will palpate injured area and surrounding area for indentations, crepitus, deformities, atrophy, pulse, pain location, sensation, and temperature.
   c. If crepitus exists, the AT will conduct fracture tests. If tests are positive, the AT will splint the injured area and refer for radiographs.
   d. Lack of pulse indicates neurovascular compromise. The athlete will be referred for emergency care.

5. Range of Motion (ROM—only tested if fracture/dislocation has been ruled out): AT will have athlete actively move injured area to determine pain free ROM. Passive and resisted ROM will also be tested if not contraindicated.

6. Special Tests: AT will use special tests to determine severity of injury. Tests will be conducted so that the most severe injury will be ruled out first for that area.
   a. Neurovascular compromise
   b. Fracture/Dislocation
   c. Muscle Strain
   d. Ligament Sprain

Protocol for Physician Referral/Appointments
If the injury warrants a physician examination, student-athletes may either see their own physician or the team physician. In the fall, student-athletes also have the option of going to the Saturday Morning clinics sponsored by the Center of Sports Medicine and Orthopedics. These clinics take place at Center of Sports Medicine and Orthopedics office on McCallie Avenue. Athletes must report Saturday morning at 9 am to be seen at the clinic.

Protocol for Treatment & Rehabilitation
The goal for treatment and rehabilitation is to decrease pain and to return the athlete to pre-injury status. Strength and Range of Motion should be nearly equal bilaterally by the completion of the rehabilitation program.

Initial Treatment
1. Ice: to help prevent secondary cell death and decrease pain
   a. AT must determine if there are any contraindications prior to the application of ice
      1. Allergies (Cold Uticaria): Hives over treatment area
      11. Raynaud's Phenomenon: blue/grayish skin; intense burning and tingling over treatment area
      m. Cold Induced Hemoglobinuria: dark urine & back pain
      iv. Cryoglobulinemia: Skin discoloration & dypsnea
   2. Compression: Limit swelling and secondary cell death
      a. AT must rule out fracture & compartment syndrome before applying compression
b. Continuous Compression (i.e. ACE © wrap around ankle)
c. Focal Compression (i.e. Horseshoe around lateral malleolus)

3. Elevation: Limit swelling and secondary cell death
   a. Keep limb elevated above the heart to limit the accumulation of swelling in injured area

4. Prohibit heat for the first 72 hours: heat will increase the amount of swelling in the injured area

5. Send recommended care form home with student-athlete to provide parents/guardians with care guidelines and contact source (Appendix I).

Continued Treatment

1. Reduce pain: AT may use the following to decrease athlete's pain
   a. Cryotherapy (Cold Therapy): Includes, but not limited to:
      i. Ice Packs: ice in plastic bag wrapped to injured area. Treatment time is 20-30 minutes. Over smaller areas or over superficial nerves, treatment time is reduced.
      n. Commercial Cold Packs: Acceptable if ice is not available. Put barrier (i.e. towel) between athlete and cold pack. Treatment time is same as ice pack.
      m. Ice Cups: Water frozen in paper cup. To use, tear paper cup away to expose ice and rub vigorously over injured area. Most commonly used with trigger points and muscle contusions. Treatment time is 5-10 minutes depending on injury area size.
        iv. Slush buckets (submerge injury in ice/water mix): Prevent frostbite by using coverings for the fingers/toes. Have student-athlete move area to break thermopane. Treatment time is 15-20 minutes
      v. Cold Water Circulating Units: Apply sleeve over treatment area. Wear for 20-30 minutes.
      vi. Vapocoolant Spray: Determine if student-athlete is allergic to any chemicals before use. Hold spray 1-1112 feet away from injury site and spray in strips. Use no more than 2x a day
      vii. Cold Whirlpool: Never leave student-athlete unattended while in the whirlpool. Student-athletes with skin infections are not allowed in whirlpool. Pool should be between 50-60 °F. Position student-athlete comfortable and fully submerge injury area. Turn jets on to break thermopane. Treatment time is 20-30 minutes.
   b. Electrotherapy: Contraindications include: infection, malignancies, muscle stimulation over fracture, pregnancy, electrode placement over carotid artery. Electrotherapy includes, but is not limited to:
      1. Unipolar Alternating Current: uses electricity to stimulate pain relief. AT should set machine at appropriate settings depending on desired pain model. Treatment time is 15-
30 minutes, or as long as the student-athlete can tolerate for pain model III.

n. Bipolar (Premodulation): See Unipolar

ii. Quadrupolar (Interferential): See Unipolar

2. Increase ROM/Prepare student-athlete for rehabilitation exercises (Appendix J):
   a. Thermotherapy (Heat Therapy): Contraindicated within the first 72 hours of an acute injury. Other contraindications include peripheral vascular disease, sensory loss, or over areas of impaired circulation. Thermotherapy includes, but is not limited to:
      i. Moist Heat Pack (Hydrocollator): Pad soaked in 170°F water and wrapped in terry cloth covers. The pad is then put over the injury site. Treatment time is 10-20 minutes.

III. Paraffin Bath: Used for small irregular areas and decreased ROM. Should not be used over areas that have open wounds. Injury area should be dipped in paraffin 6-12 times and allowed to dry. Treatment time is 15-20 minutes.

iii. Warm Whirlpool: See Cold Whirlpool for guidelines. Pool should be kept at 98-110°F. Treatment time is 20-30 minutes.

iv. Ultrasound: Uses acoustic (sound) waves to produce heat in the treatment area. Ultrasound can be used with contusions and other soft tissue injuries. Should not be used over fracture sites, the spinal column, epiphyses, or metal implants. Acoustic waves cannot travel through the air so a coupling agent must be used. Intensity is dependent on depth of treatment area. Duration of treatment is dependent on size, but usually between 5-10 minutes.

b. Passive Exercise: Student-athlete remains relaxed as the AT passively moves the joint though it's normal ROM. This technique is used to increase ROM at a specific joint.

3. Increase/Regain Strength:
   a. Active Exercise: Student-athlete actively moves the joint through its full ROM by contracting and controlling the muscles that move the joint.
   b. Active Assistive Exercise: Student-athlete actively moves joint through full ROM with AT assistance during points of weakness. The goal is for the student-athlete to regain enough strength to move joint through the full ROM without assistance.
   c. Resisted Exercise: Once student-athlete can complete full ROM without assistance, resistance may be added. Resistance can be manual (provided by AT), resistive tubing, hand-held or ankle weights.
d. Isometric Exercise: Used to strengthen muscles at a specific point in the ROM, most commonly post-surgical when full ROM is contraindicated. Resistance is applied at a specific point and no movement occurs at the targeted joint.

e. Isotonic Exercise: Used to gain strength in the muscles through a full ROM. Resistance can be applied through the use of hand-held weights, resistive tubing, gravity, etc.

f. Isokinetic Exercise: Usually used with an isokinetic machine. Maintains weight and speed through the full ROM. Can be used for strength building and measurements for baseline testing, return to play decisions, etc.

4. Protect the Injury

a. Taping: Various taping techniques may be used to provide additional support to the injured area.

b. Padding: Some injuries may require additional padding to prevent further injury.

c. Bracing: Some injuries may require a brace. Braces can either be obtained through the student-athlete's physician, team physician, or through a catalogue. Braces are at a cost to the student-athlete.

d. Splinting: Various injuries may need to stay splinted during activity. This will be done at the discretion of the AT.

e. Modify Participation: Some injuries require the AT to modify activity for the student-athlete. This will be done at the discretion of the AT and/or the team physician.

f. Remove from participation: Some injuries may require removal of the student-athlete from participation to prevent further injury. This will be done at the discretion of the AT and/or team physician.

Protocol for Over-the-Counter (OTC) & Prescription Drugs

The AT must have parental consent before administering any drugs to a minor (Appendix E: on emergency contact form). AT must establish if the student-athlete has any allergies before giving any drugs. In addition, according to the Rule of the Tennessee Board of Athletic Trainers (0150-1), Athletic Trainers may not administer prescription drugs without the order and under the supervision of the attending physician. Such drugs must be dispensed by a licensed pharmacist or licensed physician. OTC drugs are dispensed in one dose amounts and in individual labeled packets. Protocol is as follows (with parental consent):

1. Pain Relievers/Non-Steroidal Anti-Inflammatories (NSAID): These drugs may be given for an acute injury to help prevent further swelling and to relieve pain. They are not to be given before or during a practice/game or in the event the student-athlete should sustain a head injury.

2. Pain Relievers excluding NSAIDs (i.e. Acetominophen): These drugs may be given prior to practice/game to help relieve pain.
3. **Antihistamines (i.e. Benedryl):** These drugs may be given under two conditions. The athlete is suffering from an allergic reaction (i.e. bee sting) or the athlete is suffering from seasonal allergies. Antihistamines are not recommended prior to practice/game due to the nature of the drug to cause drowsiness.

4. **Antacids:** Given only in the event of heartburn and in the dosage written on the bottle. Care will be taken to ensure that heartburn is not a sign of another worse situation (i.e. heart attack).

5. **Anti-diarrheals:** Given only in the event of diarrhea and in the dosage written on the bottle. AT will recommend physician intervention.

**Protocol for Return to Play Decisions (RTP):**
For student-athletes that obtained an injury that required physician's care, they must bring a signed note from the physician to the AT clearing them to play. For student-athletes with an injury that didn't require physician care, the athlete will undergo functional testing supervised by the AT. Once the athlete can complete functional testing without compromise, he/she will be cleared to return to play. Until the student-athlete is cleared by either the AT or a physician, he/she is not allowed to participate in practice/scrimmages/games. The AT will communicate with the coaches by a Return to Play form, as well as talking to the coaches directly as time allows.

**Return to Play Against Medical Advice:**
If the student-athlete and his/her parents/guardians wish the student-athlete to play against medical advice, the parents, student-athlete, and AT and team physician will have a meeting. At that time the injury and possible consequences of early return to play will be fully explained to the student-athlete and the parents. At the end of the meeting, all parties must sign a form releasing the AT and team physician from liability. The form will not be signed by any party until the student-athlete and parents fully understand the situation and possible consequences. (See Appendix K)

**Policies**

**Lightening/Bad Weather Policy:** The AT is responsible for monitoring weather conditions prior to the start of practices. In addition, the AT will carry a lightening detector at all times while supervising outdoor sports.

**PRIOR TO THE START OF PRACTICES/GAMES**
The AT will monitor weather conditions by checking weather.com, newschannel9.com, and by listening to the radio. Procedures will be as follows:

**Tornado Warning:** All outdoor activities are prohibited and all students and staff should go to the designated Tornado shelter (the athletics hallway in HS building).

**Tornado Watch:** All afterschool activities are cancelled for the day and athletes must go home. If the tornado watch expires before the end of the school day, extracurricular activities may take place.

**Lightening:** If radar shows lightening in the area, the AT will use the lightening detector and/or flash-to-bang method to determine the distance from the strikes. If either method indicates that lightening is within 10 miles, all outdoor activities will be postponed.
Activities may resume if the lightening ceases and there is not another strike within 10 miles for 30 minutes.

DURING PRACTICE:
In the event that inclement weather approaches, the AT will monitor the weather and direct the coaches appropriately.

Tornado Warning: All outdoor activities are prohibited and all students and staff should go to the designated Tornado shelter (the athletics hallway in HS building).

Tornado Watch: All outdoor activities are cancelled and athletes are to go home.

Lightening: The AT will carry a lightening detector and will watch the sky for lightning strike. At the first sign of lightning the AT will:

1. Determine the distance from the lightning strike using the lightening detector and/or the Flash to Bang Method.
   a. If the distance is greater than or equal to 11 miles, the AT will notify the coaches of lightening and the possibility of having to postpone practice by going indoors.
   b. If the distance is less than or equal to 10 miles the AT will notify the coaches that the conditions are dangerous and everyone must go either to the locker room or in the gym.
      i. Activities may resume if the lightening ceases and there is not another strike within 10 miles for 30 minutes
2. Monitor the storm and determine whether the lightening is getting closer or farther away by both monitoring the lightening detector and using the flash-to-bang method.

GAME/SCRIMMAGE:
Prior to the start of the game, the AT and referees will establish who will make the decision about dangerous weather conditions. Should the AT and referees agree that the AT will make the call the AT will follow the lightening/bad weather protocol:

1. Inform the game announcer that the AT will make the call and give the announcer instructions to give the spectators regarding their safety. (The AT may take the place of an announcer if no announcer is present)
   2. At the first sign of lightening the AT will determine the distance from the lightning strike.
      a. If the distance is greater than or equal to 11 miles, the AT will notify the coaches/referees of lightening and the possibility of having to postpone practice by going indoors.
b. If the distance is less than or equal to 10 miles the AT will notify the coaches/referees that the conditions are dangerous and everyone must go to their appropriate location.*

3. The referees will call the game and the game announcer/AT will give the spectators information about where to seek shelter.*

4. The AT will continue to monitor the storm and determine whether the lightning is getting closer or farther away using both the lightning detector and the flash-to-bang method.

In the event that the athletic event has been postponed, the AT will:
1. Continue to monitor the storm. The event may resume if 30 minutes passes without another strike within 10 miles. If there is another strike within the 30 minute limit, the 30 minute limit starts over.
Cancellation of any athletic event is at the discretion of the Athletic Director, coaches, and/or referees.

*Appropriate Locations:
1. Spectators: The game announcer will direct spectators to the Middle School gym. They also have the option of going to their respective cars. No one is permitted to remain on the field, they must seek shelter.
2. Referees: The AD will escort them to their designated locker room.
   3. Home Team: Their respective locker room during a game situation. During a practice they may go to the middle school gym to continue indoor practice.
   4. Visiting Team: Their locker room or the middle school gym.

Heat Policy
In an effort to help protect the health and safety of the student-athletes, the Athletic Trainer, in conjunction with the TSSAA, is implementing these procedures pertaining to heat and participation in physical activity. These procedures should serve as guidelines to conduct outdoor practices and other activities during such times as the ambient temperature and/or heat index exceeds 95 degrees.

1. This procedure calls for the determination of the ambient temperature, relative, humidity, and heat index.

2. These measurements of temperature and heat index will be taken by the following device:
   a. **Digital psychrometer**: stored and monitored by the certified athletic trainer

3. When there is a heat index and or an ambient temperature reading that exceeds 95 extreme cautions will be taken and practices will be incrementally modified based upon repeated measurements.
4. When the ambient temperature or heat index exceeds 104 degrees all outside practices will cease and be directed to go inside to a climate controlled facility.

5. Once heat procedures have been enacted the temperature and heat index will be monitored and recorded every thirty minutes until the end of activity.

**Procedure for Testing**

One hour prior to the start of activity, the AT will begin to take temperature and heat index measurements. The AT will record this information on the Heat Index form (Appendix N).

**Electronic Psychrometer:** Psychrometer should be placed in an open area as close to the location of activity as possible. The psychrometer should be placed out of direct sunlight and approximately five to six feet from the ground. Allow the psychrometer to set in the on position for at least five minutes before recording readings.
<table>
<thead>
<tr>
<th>Highest Recorded Temperature (HRT)</th>
<th>Under 95</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Practice is not limited, within reason.</td>
<td></td>
</tr>
<tr>
<td>• Allow for adequate water breaks and rest periods.</td>
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<tr>
<td>• Continue to monitor athletes for signs of heat illness</td>
<td></td>
</tr>
<tr>
<td>• Those athletes exhibiting these signs should be removed from practice and monitored in a cool shaded area, until qualified personnel clears them to go back to practice.</td>
<td></td>
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<tr>
<td>• Continue to monitor heat index every 30 minutes</td>
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<table>
<thead>
<tr>
<th>HRT 95-99</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide ample amounts of water</td>
</tr>
<tr>
<td>• Water should be provided so that athletes can drink as they feel it is needed</td>
</tr>
<tr>
<td>• Water breaks should be every 30 minutes lasting 10 minutes in duration, preferably in shaded area.</td>
</tr>
<tr>
<td>• Allow athletes to remove any excess pads during water breaks to allow for adequate cooling</td>
</tr>
<tr>
<td>• Monitor athletes carefully for signs of heat illness</td>
</tr>
<tr>
<td>• Those athletes exhibiting these signs should be removed from practice and monitored in a cool shaded area, until qualified personnel clears them to go back to practice.</td>
</tr>
<tr>
<td>• Continue to monitor heat index every 30 minutes</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>HRT 100-104</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide ample amounts of water</td>
</tr>
<tr>
<td>• Water should be provided so that athletes can drink as they feel it is needed</td>
</tr>
<tr>
<td>• Water breaks should be every thirty minutes lasting 5-10 minutes in duration, preferably in shaded area.</td>
</tr>
<tr>
<td>• Equipment such as shoulder pads and helmets should be removed as long as the temperature and or heat index stays in this range.</td>
</tr>
<tr>
<td>• Those athletes exhibiting these signs should be removed from practice and monitored in a cool shaded area, until qualified personnel clears them to go back to practice.</td>
</tr>
<tr>
<td>• Continue to monitor heat index every 30 minutes</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>HRT 105 or above</th>
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<tbody>
<tr>
<td>• All outdoor activities should be stopped, or moved to a climate controlled facility.</td>
</tr>
<tr>
<td>• Continue to provide ample amount of water even while practicing inside.</td>
</tr>
<tr>
<td>• Monitor athletes carefully for signs of heat illness. Those athletes exhibiting these signs should be removed from practice and taken to cool area until qualified personnel clears them to go back to practice.</td>
</tr>
<tr>
<td>• Continue to monitor heat index every 30 minutes</td>
</tr>
<tr>
<td>• If the heat index drops below 105 practice may be moved back outside.</td>
</tr>
</tbody>
</table>
Cleveland High School
Emergency Action Plan
Football Field

Initiate 911 first, then dial Certified Athletic Trainer (Rebecca Parker: 423-435-1679), if not already present at the event or practice. Other people involved in the EAP are Dr. Voytik, Eric Phillips (Athletic Director), and Coach Ron Crawford (Head Football Coach)

Procedures for Activating Emergency Plan

1. In the event of an injury to a student-athlete, the athletic trainer or certified first-aider should assess the extent of the injury. Always remember to wait until the official stops the game, or the head coach stops the practice and do not move athlete until responsiveness and degree of injury are assessed.

2. If a certified first-aider feels the need for assistance they should contact the Certified Athletic Trainer if she is not already present. The student athletic trainer and first-aider may assist in minor wound bandaging, ice bagging, and simple First Aid procedures; they can also make the necessary communications for other needed services.

3. When a situation is deemed life threatening (head, neck, or back injury or cardiac pathology) or serious in nature, one person should immediately activate EMS by phone. If the AED is needed, it is located inside the school right outside the door to the gymnasium (aka the Dome). The same person will instruct an assistant to clear the area located closest to the road in which the injured athlete is lying. Someone should wait on Raider Drive by the entrance to Cleveland High School, as well as the gate entrance for the road to the field house and instruct the ambulance where to go. Make sure that the area is clear and the ambulance will have plenty of space.

4. Once the ambulance arrives, EMTs will have complete control of the scene and the situation. If transporting a student-athlete is necessary, an athletic trainer or designated person should go to the hospital to provide necessary information.

Directions to Football Field

The football field is located on Raider Drive behind the Jones Wrestling Center and the baseball field. EMTs can access field by driving behind the field house and entering the field through the double gates beside the field house.

Emergency Phone Numbers

Emergency: 911
Fire Department: (423) 472-2181
Ambulance: (423) 728-7015
Lightning Emergency Action Plan
Football Field

1. If inclement weather is forecasted at game time, Rebecca (Athletic Trainer) will keep a close watch on the weather radar for Cleveland up until the competition begins. Watching www.weather.com will give her the information she needs. Prior to the beginning of the game, Rebecca will talk with both the officials and the head coaches (Coach Ron Crawford) about the upcoming storm, where the safe location is (the Field House and the Jones Wrestling Center), and that she will keep track of the distance the storm is from the field.

2. Since Cleveland High School does not own a lightning detector, the “Flash Bang” method will be used to determine the distance of the storm. To use the Flash Bang method, count the seconds from the time lightning/flash is sighted to when the clap/bang of thunder is heard. Divide this number by 5 and equals how far away (in miles) the lightning is occurring. Activities will be terminated at the 40 seconds or 8 miles mark.

3. If lightning is in the immediate area, Rebecca will notify Coach Crawford (Head Football Coach) and the referees about the inclement weather and that everyone needs to take shelter. Teams may return to the field, with Rebecca’s permission only, 30 minutes after the last sight of lightning. Both teams may use the Football Field House or the Jones Wrestling Center as shelter from the lightning storm. Fans will also be warned about the upcoming storm and be advised to take shelter throughout the duration of the storm. Unsafe shelter areas include open fields, metal objects (bleachers, fences, etc.), individual tall trees, and light poles.

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

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

6. In case of an emergency situation in which someone is injured due to lightning, the phone numbers used in the Football EAP will help get the proper authorities to the football field.
General Emergency Information

In the event of an emergency: Dial 911

School’s Address:
750 Lauderdale Memorial Hwy,
Cleveland, TN 37312

The closest intersection to the school is I-75 and Lauderdale Memorial Hwy.

Landline Locations:

• Main Office (423) 336-1383

Emergency Contact Information:

• Cleveland Police Non-Emergency Number (423) 476-7511
A. INTRODUCTION:

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

Athletic departments have a duty to develop an emergency plan that will be implemented when necessary, therefore providing appropriate standards of emergency care. As athletic injuries may occur at any time and during any activity, the sports medicine team must be prepared. This preparation involves formulation of an emergency plan, proper coverage of events, maintenance of appropriate emergency equipment and supplies, utilization of appropriate emergency medical personnel, and continuing education in the area of emergency medicine and planning. Hopefully, through careful pre-participation physical screenings, adequate medical coverage, safe practice and training techniques and other safety avenues, some potential emergencies may be averted. However, accidents and injuries are inherent with sports participation, and proper preparation on the part of the sports medicine team should enable each emergency situation to be managed appropriately.
Walker Valley High School has a written emergency plan that should be followed in the event of a medical emergency. All coaches should be familiar with this document and their role and responsibility in an emergency. Any questions should be directed to the head athletic trainer (or school administrator, in the absence of an athletic trainer).

An emergency is the need for Emergency Medical Services (EMS) to give further medical attention and/or transport an athlete to the hospital. It is important in these situations that coordination between the athletic trainer, coaches, administrators and student responders be effective. This guide is intended to delineate roles and outline the protocol to be followed should an emergency occur.

Situations when 911 should be called are:
- An athlete is not breathing
- An athlete has lost consciousness
- It is suspected that an athlete may have a neck or back injury
- An athlete has an open fracture (bone has punctured through the skin)
- Severe heat exhaustion or suspected heat stroke
- Severe bleeding that cannot be stopped
- Any other type of life threatening injury

B. EMERGENCY PERSONNEL - Chain of Command
1. Team Physician
2. Certified Athletic Trainer
3. Athletic Director
4. Administrator
5. Head Coach
6. Assistant Coach
7. School Resource Officer
8. Sports Medicine Student Assistant
9. Other Athletes

The highest person in the chain of command who is present at a scene will be the designated person in charge, or leader. That person is responsible for deciding whether or not to call 911, instructing others how they may be of help and will be the person who stays with the athlete until EMS arrives. However at any point in time if someone feels the need due to a life threatening situation, they can call 911 it isn’t solely the responsibility of the emergency personnel.
Once it has been decided that EMS should be called, the following protocol should be followed:

C. EMERGENCY ACTION PLAN STEPS:

1. The highest person on the chain of command will be deemed the leader, they will first establish the scene as safe once this has been achieved they will stay with the athlete and monitor their condition while administering necessary first aid. If possible, someone else on the chain of command should also stay and assist. The front office or an administrator should be notified that there is an emergency situation on campus.

2. The highest person on the chain of command will make the call to EMS or will designate another person to make the call.

3. EMS/911 can be called from a cell phone or land line located in the main office, wellness office.

   • Providing Information:
     - Name, address, telephone number of the caller
     - Nature of emergency (medical or non-medical*)
     - Number of athletes
     - Condition of athlete(s)
     - First Aid treatment initiated by the first responder
     - Specific directions as needed to locate the emergency scene
     - DO NOT HANG UP UNTIL EMS HANGS UP FIRST.

Walker Valley High School is located at: 750 Lauderdale Memorial Hwy
Cleveland, TN 37312

• The closest intersection to the school is I-75 and Lauderdale Memorial Hwy.

4. Another person will be in charge of retrieving the emergency equipment from its designated location and returning to the leader as soon as possible. This can be a good job for a student trainer or coach.

5. The leader will send runners to all intersections between where the athlete is located and the School/venue-specific location to direct the ambulance to the athlete. The runners should stay in their positions and wave the ambulance through the proper turns to get to the athlete.

6. The leader will designate another person to attempt contact with the athlete’s parents. Emergency contact information can be found in the athlete's physical form which coaches and athletic trainers should have with them at all times. If a parent is present they are to be located and brought to the area to be transported with EMS.
7. If transport is deemed necessary by EMS, the athlete will be taken Sky Ridge Medical Center: 2305 Chambliss Ave NW, Cleveland TN unless the parent requests otherwise.

D. ROLES OF THE EMERGENCY TEAM MEMBERS

First Responder Responsibilities
1. Assess athlete, if a student has collapsed and is not responsive, assume CPR
2. Identify person to activate Emergency Medical System (call 911 or notify EMS if present).
3. Identify person to retrieve emergency equipment such as an AED or other first aid supplies if needed.
4. Lead/coordinate CPR efforts if appropriate until EMS personnel are present to assume care.
5. Identify person to direct EMS to the scene.
6. Identify person to do crowd control. Only persons involved in the care of the athlete should be present.
7. Identify person to contact parents. This person should retrieve students emergency information that all coaches are required to have on hand. They should also share this information with the person designated to call EMS.

Person activating Emergency Medical System responsibilities
1. Call 911 immediately.
2. Be prepared to give as much information as possible including:
   a. Your name, address, telephone number of caller
   b. Why you are calling (student collapsed while practicing football)
   c. Condition of athlete (breathing, pulse, level of consciousness, etc)
   d. Any treatment initiated by first responder
   e. Location of athlete
   f. Directions if needed.
   g. Other information requested by dispatcher
3. After ending call, report back to FIRST RESPONDER that EMS has been called and is on the way.

Person retrieving Emergency Equipment responsibilities
1. Retrieve AED first and return to scene. Notify FIRST RESPONDER that the AED is present.
2. All teams have a first aid kit but additional supplies such as splints, slings can be obtained from the sidelines where the Athletic Trainers kit is located.

Person directing EMS to scene responsibilities: (Assistant Coach, Administrator, Athletic Director)
1. If more than one person is needed, request additional help.
2. Go to entrance of area. Be sure gates are open. If area is not easy to locate, you may want to have several people to get into strategic areas to “flag down” EMS personnel and direct them to the scene.
Person doing crowd control responsibilities: (SRO, Assistant Coach, Administrator, and Athletic Director)
1. Limit scene to necessary people. Move bystanders away from area.
2. If CPR is in progress, there will need to be several people available to do chest compressions, etc. Determine a couple of people trained in CPR that can assist with this. Have them stand to the side a few feet behind the person doing chest compressions.
3. If the parents/family are present, have someone stand with them for support. Do not try to remove the family but try to prevent them from hindering care.

Person that will contact the parent responsibilities: (Assistant Coach, Administrator, Athletic Director)
1. Obtain information to relay to parents. Emergency contact information and emergency treatment forms are kept in the training kit or head coaches bag.
2. Information needed to share may include:
   a. Your name
   b. Brief description of event leading to student’ emergency. (John collapsed during football practice)
   c. Current condition (he is awake and talking)
   d. Any treatment received
   e. Other pertinent information. (EMS is here and has started an IV)
   f. Which hospital the student will be transported to.
3. Be prepared to give parents directions to hospital if needed.

During home games, the home team ATC and the visiting ATC are responsible for their own teams but may assist the other ATC if needed. Since there is only one ATC on campus, all coaches are responsible for emergencies during practice and games until ATC, EMS, or doctor arrives on scene. The Head coach is in charge of contacting the Athletic Director, Athletic Trainer, and any other school administrator when an emergency situation has occurred. Each Coach should have a current CPR/AED and first aid certification and should be aware of how to perform the EAP when it is needed.

Documentation
Medical records such as physicals and emergency contact information for an athlete is located in a locked filling cabinet in the Athletic Training Room. The head coach is responsible for having a copy of their athlete’s medical records with them at all times. In the absences of a parent a copy of the athletes medical records should accompany them to the hospital.
E. EMERGENCY EQUIPMENT

- Emergency equipment could include: spine boards and straps, automated external defibrillators (AEDs), AED pads, AED batteries, splinting equipment, helmet removal equipment (trainers angle, electrical screw driver) and their batteries, etc.

- Personnel should be familiar with the function and operation of each type of emergency equipment. Equipment should be in good operating condition, and personnel must be trained in advance to use it properly. Emergency equipment should be checked on a regular basis and use rehearsed by emergency personnel. The emergency equipment available should be appropriate for the level of training for the emergency medical providers.

  - EMT Present: signal to the EMT that assistants is needed, they will have the needed emergency equipment (spine board, cervical collar, AED, splints, etc.)
  - ATC Present: AED, trainers angle, smaller splints, bandages and dressings will be on the sidelines of the field (no spine board, cervical collar, large splints)
  - ATC NOT Present: AED (locate nearest AED) and whatever medical supplies each sport has in their possession

Location of AED’s
1. Arena: Located on the Wall of the main entrance to the arena.
2. Portable AED: Is located with the ATC, it is kept in the training room.

*Coaches should take note of the closest AED to their practice and game locations.

F. MEDICAL EMERGENCY TRANSPORTATION

Emphasis is placed on having an ambulance on site at high risk sporting events, such as football, gymnastics, track and field meets, etc. In the event that an ambulance is on site, there should be a designated location with rapid access to the site and cleared route for entering/exiting the venue. In the event that an ambulance is not on site, the medical personnel should be aware of average EMS response time for the athletic venue and distance from the venue to local hospitals. Care must be taken to ensure that the activity areas are supervised should the emergency care provider leave the site.

- Any emergency situation where there is impairment in loss of consciousness (LOC), airway, breathing, or circulation (ABCs) or there is a neurovascular compromise should be considered a “load and go” situation and emphasis placed on rapid evaluation, treatment, and proper transportation.

In order to provide the best possible care for Bradley Central athletes it is highly encouraged to send athletes to Sky Ridge Medical Center. Since insurance coverage varies among athletes, parents may decide how their athlete is cared for and where they are cared for. Parents are the primary person to accompany student to hospital. If parents are not around, assistant coach will accompany athlete to hospital along with their
physical and consent form. Emergency care providers should refrain from transporting unstable athletes in inappropriate vehicles.

G. VENUE DIRECTIONS (CORRESPONDS TO NUMBERS ON THE MAP)

1. Soccer Field:
   • Directions from the front entrance of the school: enter the school through the main entrance on Lauderdale Memorial Hwy. As you approach the school, turn right going toward the back part of the school and enter through the gate. The soccer field is located on the left hand side directly in front of the softball field.

2. Arena (Basketball/Volleyball/wrestling):
   • Directions from the front entrance of the school: enter the school through the main entrance on Lauderdale Memorial Hwy. Turn Right before you reach the school main entrance. Follow the road around to the back of the school. Just past the garden area, there is a parking lot for the gymnasium. The gymnasium is just through the double doors.

3. Walker Valley Stadium Field:
   • Directions from the front entrance of the school: enter the school through the main entrance on Lauderdale Memorial Hwy. Turn Left going in front of the school. Go straight through the stop sign and follow the road till the end. Turn Left go through the gate and just right of that road is the gate to the football field.

1. Football practice Field:
   • Directions from the front entrance of the school: enter the school through the main entrance on Lauderdale Memorial Hwy. As you approach the school, turn Right going toward the back part of the school and enter through the gate. Just past the soccer field is a gravel drive. Turn Left onto the gravel drive, go up the hill and the practice field is on the right hand side just across the backside of the field house.

Baseball Field:
   • Directions from the front entrance of the school: enter the school through the main entrance on Lauderdale Memorial Hwy. Turn Left going in front of the school. Go straight through the stop sign and follow the road till the end. Turn Left and go through the gate past the football field. Just before the end of the road, the baseball field will be on your Right.
   •

6. Softball Field:
   • Directions from the front entrance of the school: enter the school through the main entrance on Lauderdale Memorial Hwy. As you approach the school, turn Right going toward the back part of the school and enter through the gate on your right. Just past the soccer field before you reach the end of the road, there is a gravel parking lot where the softball field is located.
7. Track:
• Directions from the front entrance of the school: enter the school through the main entrance on Lauderdale Memorial Hwy. Turn Left going in front of the school. Go straight through the stop sign and follow the road till the end. Turn Left go through the gate and just right of that road is the gate to the football/track field.

Heat Policy for TSSAA
TSSAA guidelines for Heat Index readings are as follows:
Under 95 degrees = Provide ample water. Water is always available and athletes have unrestricted access. Optional water breaks every 30 minutes for 10 minute time frames. Ice-down towels are available. Athletes should be monitored carefully. Re-check heat index every 30 minutes.
95-99 degrees = Provide ample water. Water is always available and athletes have unrestricted access. Mandatory water breaks every 30 minutes for 10 minute time frames. Ice-down towels are available. Reduce time outside or move indoors to air conditioning if possible. Postpone practice to later in the day if possible. Contact sports should remove helmets or extra equipment when in non-contact practice. Re-check heat index every 30 minutes.
100-104 degrees = Provide ample water. Water is always available and athletes have unrestricted access. Mandatory water breaks every 30 minutes for 10 minute time frames. Ice-down towels are available. Alter uniforms by removing items/layers if possible. Allow changes to dry shirts and shorts if possible. Reduce time outside or move indoors to air conditioning if possible. Postpone practice to later in the day if possible. Contact sports should remove helmets or extra equipment when in non-contact practice. Re-check heat index every 30 minutes.
105 and Above = Stop all outside activity including practice or play. Stop all indoor activity if air conditioning is not available and the heat index indoors is 105° or greater.