



2026 - 2027



SPORTS MEDICINE PACKET



Sports Medicine Table of Contents

NFHS Sports Medicine Advisory Committee (SMAC).....	3
Required Courses for all Coaches.....	4
WVSSAC Return to Play Protocol.....	5
WVSSAC Policy and 2013 Legislation.....	6
Concussion 101.....	7
Concussion FACT Sheet.....	8
Parents' Guide to Concussion.....	12
WVSSAC First Aid & CPR Training.....	18
WVSSAC Body Fluid Standard Precautions.....	19
NFHS Sports Related Skin Infections.....	21
Protect Yourself: Avoid Common Skin Conditions.....	24
A Players Guide: Prevent Skin Infections.....	25
NFHS Sports Hygiene, Skin Infections and Communicable Diseases.....	26
Taking the Sting out of Skin Injuries.....	28
CDC – Recommendations for School Athletic Teams.....	29
WVSSAC Heat Acclimatization/ Heat Illness.....	30
NFHS Heat Acclimatization and Heat Illness Prevention.....	33
Heat Acclimatization Chart.....	37
Beat the Heat Flyer.....	38
WVSSAC Sudden Cardiac Arrest Awareness.....	39
Coaches 10 Legal Duties.....	40
Tobacco Policy Announcement.....	41
Opioid Addiction Flyer.....	42
Emergency Action Plan (EAP).....	43
NFHS Handling Events During Lightning or Thunder.....	45
WVSSAC Physical Form.....	47



NFHS SPORTS MEDICINE ADVISORY COMMITTEE (SMAC)

Mission Statement

The mission of the Sports Medicine Advisory Committee (SMAC) is to provide information, vision, guidance and best practices to the National Federation of State High School Associations (NFHS), which focus on the health and safety of students participating in interscholastic sports and activities.

Goals of the Committee

- Advise the NFHS and member associations on medical and safety issues and conditions as they relate to interscholastic sports and activities rules writing and guidelines, as well as other programs and services the NFHS administers.
- Monitor, evaluate and disseminate current sports medicine information to the NFHS and member associations.
- Assist the NFHS in identifying, prioritizing and researching sports medicine issues. The committee will proactively address health and risk management issues of general and specific concern to the NFHS, member associations and participating students.
- Work cooperatively with the NFHS rules-writing committees to address sports medicine issues as they impact high school rules and the health and risk management of its participating students.
- Work cooperatively and maintain liaisons with sports medicine, sports industry and other related organizations that may assist the committee in its work.
- Advise the NFHS when deemed necessary and possible on questions regarding protective or special equipment not specifically addressed in the NFHS playing rules.
- Develop, review and revise NFHS position statements and guidelines to assist the NFHS leadership and membership in making informed decisions that contribute to minimizing risk associated with student participation in interscholastic sports and activities.
- Analyze and interpret the scientific injury data that is obtained from the National High School Sports-Related Injury Surveillance System (High School RIO™). This information will allow the SMAC to initiate and support recommendations to the NFHS community intended to reduce risk through possible changes in rules, guidelines, best practices and/or equipment.
- Provide the NFHS leadership and membership current information on sports medicine issues through the NFHS Sports Medicine Handbook, the Sports Medicine section of the NFHS website and through other NFHS publications.

Reviewed and approved by NFHS SMAC in April 2023

April 2018

April 2014

October 2010

IMPORTANT: REQUIRED COURSES FOR ALL COACHES

ALL coaches are required to complete the “Concussion in Sports” online course as well as the “Sudden Cardiac Arrest” online course ANNUALLY. The “Heat Illness Prevention” online course must be completed on time for all new coaches. The courses are free and links to the courses may be found on the WVSSAC homepage at www.wvssac.org.

<https://nfhslearn.com/courses/61037/concussion-in-sports>

<https://nfhslearn.com/courses/sudden-cardiac-arrest>

<https://nfhslearn.com/courses/heat-illness-prevention-2>

SUGGESTED COURSES

NFHS “Heat Acclimatization and Heat Illness Prevention Position Statement”

<https://a-us.storyblok.com/f/1022696/x/42da7079ed/heat-acclimatization-and-heat-illness-prevention-position-statement-final-10-6-25.pdf>

NFHS “Position Statement and Recommendations for Maintaining Hydration to Optimize Performance and Minimize the Risk for Exertional Heat Illness”

<https://a-us.storyblok.com/f/1022696/x/fd2b8d7658/nfhs-hydration-position-statement-final-10-6-25.pdf>

NFHS “Position Statement on Physical Activity, Air Quality and Wildfires

<https://www.nfhs.org/media/7212236/nfhs-position-statement-on-air-quality-april-2023-final.pdf>

NFHS “Emergency Action Plan (EAP) for Interscholastic Activities Position Statement”

<https://assets.nfhs.org/umbraco/media/7213372/nfhs-smac-emergency-action-plans-eap-position-statement-final-10-7-24.pdf>

NFHS “The Collapsed Student” Online Course from NFHSLearn.com

<https://nfhslearn.com/courses/the-collapsed-athlete>

NFHS “Emergency Action Planning for Afterschool Programs” Online Course from NFHSLearn.com

<https://nfhslearn.com/courses/emergency-action-planning-for-afterschool-programs>

NFHS “CPR and AED Training” Online Course from NFHSLearn.com

<https://nfhslearn.com/courses/cpr-aed>

Other resources are available on the following link to the NFHS Sports Medicine web page: <https://nfhs.org/resources/sports-medicine>



WVSSAC

Return to Play (RTP) Protocol

An athlete removed from a contest that shows signs/symptoms of a concussion shall be immediately evaluated by an appropriate health care professional. If no appropriate health care professional is available, the athlete shall not be allowed to RTP.

When the athlete is evaluated by the appropriate health care professional, if it is determined the athlete has suffered a concussion, the athlete shall not be permitted to RTP until successful completion of the progressions and clearance to RTP. If it is determined by the appropriate health care professional that the athlete did not suffer a concussion, the athlete may be returned to play as deemed appropriate by the health care professional. In all cases, when an athlete has been evaluated for signs and symptoms, the concussion report must be submitted within 7 days.

RTP shall be delayed until athlete is asymptomatic and has undergone a progression of tests to determine if they are able to RTP. **Each step / test in the progression takes 24 hours (1 per day)**

The progression shall follow: (Neuro-cognitive testing is strongly recommended.)

- No activity with complete physical and cognitive rest
- Light aerobic exercise (less than 70% of maximum heart rate)
- Sport specific exercise (drills specific to the athlete's sport)
- Non-contact training drills (more intense sport drills with no contact from other players)
- Full participation practice (following written medical clearance)
- Return to Play (normal game play)

If any symptoms occur during the progression, the athlete should rest for 24 hours before attempting the same progression again.

Appropriate Health Care Professional

Note: Any of the following who have appropriate training in the evaluation and management of head injuries.

- Medical Doctor (MD)
- Doctor of Osteopathy (DO)
- Doctor of Chiropractic (DC)
- Advanced Registered Nurse Practitioner (ARNP)
- Physician Assistant (PA-C)
- Licensed or Registered Certified Athletic Trainer (ATC/R, LAT, ATC)
- Licensed Physical Therapist

Approved Board of Directors 5/06/10. Revised May 2019

Concussions

WVSSAC Policy and 2013 Legislation – Senate Bill 336

Based on the recommendation of the Sports Medicine Advisory Committee, the Board of Directors approved the following at its June **2016** meeting.

- 1) ALL COACHES will be required to annually complete the NFHS Concussion Course.
- 2) The principal shall monitor and maintain appropriate records regarding completion of the course.
- 3) **ANY COACH** that does not complete the NFHS Concussion Course annually will not be permitted to coach until the course has been completed.
- 4) Make concussion information available to parents and athletes.
 - Physical Form
 - CDC Letter
 - Parents' Guide to Concussions in Sports
- 5) Return to Play protocol (RTP) – Must have written permission to RTP from a health care professional with training in the evaluation of head injuries.
- 6) WVSSAC Concussion Report – Required online submission to school administration. Report must be submitted to Dr. Dan Martin, martin_d1@wvwc.edu within seven (7) days of the injury. Report may be accessed at www.wvssac.org under the Forms tab.

Information/ directions regarding the NFHS Concussion Course may be found at www.nfhsllearn.com.

Additional information regarding concussions may be found on the Sports Medicine tab at the WVSSAC website, www.wvssac.org

CONCUSSION 101

WITH MORE ATTENTION BEING PAID TO CONCUSSIONS, they're no longer being thought of as simple "bumps on the head" or "bell-ringers." Help keep young athletes protected by better understanding the symptoms, treatment and prevention of concussions.

- A concussion is defined as a "trauma-induced alteration in mental status that may or may not involve loss of consciousness."
- This can be caused by a bump, blow or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth.
- Concussion signs and symptoms can appear immediately or not be noticed until days or even weeks after the injury.

HOW TO REMAIN SAFE ON THE FIELD

- Make sure all helmets and safety equipment are sport specific, properly fitted and refurbished according to industry standards.
- Follow sports safety rules and use proper techniques.
- Practice good sportsmanship.

YOU HAVE A CONCUSSION – NOW WHAT?

- **Report symptoms:** Tell a coach, parent or athletic trainer if you suspect an athlete has a concussion.
- **Get checked out:** Only a health care professional experienced with concussion management can tell if a concussion has occurred and when it is OK to return to play.
- **Rest and gradually return to activity:** After resting for the first 24 to 48 hours, gradually return to activities. It's OK to return to daily living with mild symptoms, just be cautious as to not exacerbate symptoms.
- **Give time to recover:** It's important to allot time to heal. Another concussion sustained while the brain is healing can result in long-term problems or even death in rare cases.
- **Take it slow at first:** After the physician or athletic trainer gives the OK to return to activity, an athlete shouldn't jump in all at once. The athletic trainer will work with the athlete to develop a safe plan for progressively returning to play.
- **Seek more information:** If there are concerns or questions, don't hesitate to bring them up to a health care provider such as an athletic trainer or physician.

KNOWING THE RED FLAGS

- CAN'T BE AWAKENED
- REPEATED VOMITING

- SLURRED SPEECH
- CAN'T RECOGNIZE PEOPLE OR PLACES



- WORSENING HEADACHE
- SEIZURES



- LOOKS LESS ALERT



- BALANCE PROBLEMS
- DIZZINESS

- INCREASING CONFUSION OR IRRITABILITY
- LOSS OF CONSCIOUSNESS
- WEAKNESS OR NUMBNESS IN ARMS OR LEGS
- UNUSUAL BEHAVIORAL CHANGE



- BOTHERED BY LIGHT OR NOISE
- SLOWED REACTION TIME
- SLEEP PROBLEMS



Sources: NATA, Sanford Orthopedic Sports Medicine, Center for Disease Control and Prevention, Heads Up Concussion, Fifth Annual Youth Sports Safety Summit

Infographic provided by the National Athletic Trainers' Association (Updated 2023)

A FACT SHEET FOR High School Coaches



CDC HEADS UP
SAFE BRAIN. STRONGER FUTURE.

Below is information to help high school coaches protect athletes from concussion or other serious brain injury, and to help coaches know what to do if a concussion occurs.

What is a concussion?

A concussion is a type of traumatic brain injury caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth. This fast movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging brain cells.

What is a subconcussive head impact?

A subconcussive head impact is a bump, blow, or jolt to the head that *does not* cause symptoms. This differs from concussions, which *do* cause symptoms. A collision while playing sports is one way a person can get a subconcussive head impact. Studies are ongoing to learn about subconcussive head impacts and how these impacts may or may not affect the brain of young athletes.

How can I keep athletes safe?

As a high school coach, your actions can help lower an athlete's chances of getting a concussion or other serious injury. Aggressive or unsportsmanlike behavior among athletes can increase their chances of getting a concussion or other serious injury.³ Here are some ways you can help:

Talk with athletes about concussion:

- Set time aside throughout the season to talk about concussion.
- Ask athletes about any concerns they have about reporting concussion symptoms.
- Remind athletes that safety comes first and that you expect them to tell you and their parent(s) if they think they have experienced a bump, blow, or jolt to their head and “don’t feel right.”

Focus on safety at games and practices:

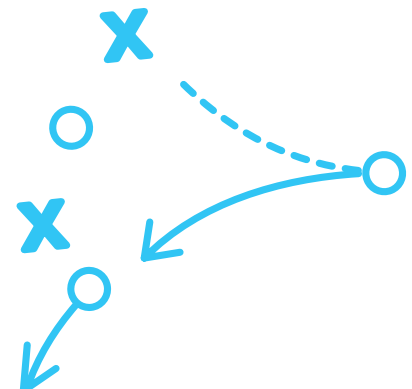
- Teach athletes ways to lower the chances of getting a hit to the head.
- Enforce rules that limit or remove the risk of head impacts.
- Tell athletes that good sportsmanship is expected at all times, both on and off the field.
- Be sure to also work closely with your team’s athletic trainer, when available, to promote concussion safety.

Multiple concussions

Athletes who have ever had a concussion have a higher chance of getting another concussion. A repeat concussion can lead to more severe symptoms and longer recovery.^{1,2}

Coach’s to-do list:

- ✓ Talk with athletes about concussion.
- ✓ Teach athletes ways to lower their chances of getting a hit to the head.
- ✓ Encourage concussion reporting among your athletes.
- ✓ Know what to do if you think an athlete has a concussion.
- ✓ Learn how to help an athlete safely return to play after a concussion.



Make sure athletes do not perform these unsafe actions:

- Use their head or helmet to contact another athlete.
- Make illegal contact or check, tackle, or collide with an unprotected opponent.
- Try to injure another athlete.

Stay up to date on concussion information:

- Review your state, league, or school's concussion plans and rules.
- Take a training course on concussion. The Centers for Disease Control and Prevention (CDC) offers free concussion training at cdc.gov/HEADSUP.
- Download CDC's HEADS UP app or another resource that provides a list of concussion signs and symptoms.

Check equipment and sports facilities:

- Make sure all athletes wear a helmet that is appropriate for the sport or activity; ensure that the helmet fits well and is in good condition.
- Work with the game or event manager to fix any concerns, such as tripping hazards or goal posts without proper padding.

One study found that nearly 70% of athletes continued to play with concussion symptoms.⁴



How can I spot a possible concussion?

Athletes who show or report one or more of the signs and symptoms listed below—or who simply say they just “don’t feel right”—after a bump, blow, or jolt to the head or body may have a concussion or other serious brain injury. Concussion signs and symptoms often show up soon after the injury, but it can be hard to tell how serious the concussion is at first. Some symptoms may not show up for hours or days.

Signs coaches or parents may observe:

- Seems confused
- Forgets an instruction or is unsure of the game, position, score, or opponent
- Moves clumsily
- Answers questions slowly or repeats questions
- Can't remember events before or after the hit, bump, or fall
- Loses consciousness (even for a moment)
- Has behavior or personality changes

Symptoms athletes may report:

- Headache
- Nausea or vomiting
- Dizziness or balance problems
- Bothered by light or noise
- Feeling foggy or groggy
- Trouble concentrating or problems with short- or long-term memory
- Does not “feel right”

Signs of a more serious brain injury

In rare cases, a concussion can cause dangerous bleeding in the brain, which puts pressure on the skull. Call 9-1-1 if an athlete develops one or more of these danger signs after a bump, blow, or jolt to the head or body:

- A headache that gets worse and does not go away
- Significant nausea or repeated vomiting
- Unusual behavior, increased confusion, restlessness, or agitation
- Drowsiness or inability to wake up
- Slurred speech, weakness, numbness, or decreased coordination
- Convulsions or seizures (shaking or twitching)
- Loss of consciousness (passing out)

Some athletes may not report a concussion because they don't think a concussion is serious.

They may also worry about:

- Losing their position on the team or losing playing time during a game,
- Putting their future sports career at risk,
- Looking weak,
- Letting down their teammates or the team, and/or
- What their coach or teammates think of them.⁵⁻⁷

What should I do if an athlete has a possible concussion?

As a coach, if you think an athlete may have a concussion, you should:

Remove the athlete from play.

When in doubt, sit them out! Record and provide details on the following information to help the school nurse, athletic trainer, or first responders assess the athlete after the injury:

- Cause of the injury and force of the hit or blow to the head or body
- Any loss of consciousness (passed out) and for how long
- Any memory loss right after the injury
- Any seizures right after the injury
- Number of previous concussions (if any)

Keep an athlete with a possible concussion out of play on the same day of the injury and until cleared by a healthcare provider.

Do not try to judge the severity of the injury yourself. Only a healthcare provider should assess an athlete for a possible concussion and decide when it is safe for the athlete to return to play.

Inform the athlete's parent(s) about the possible concussion.

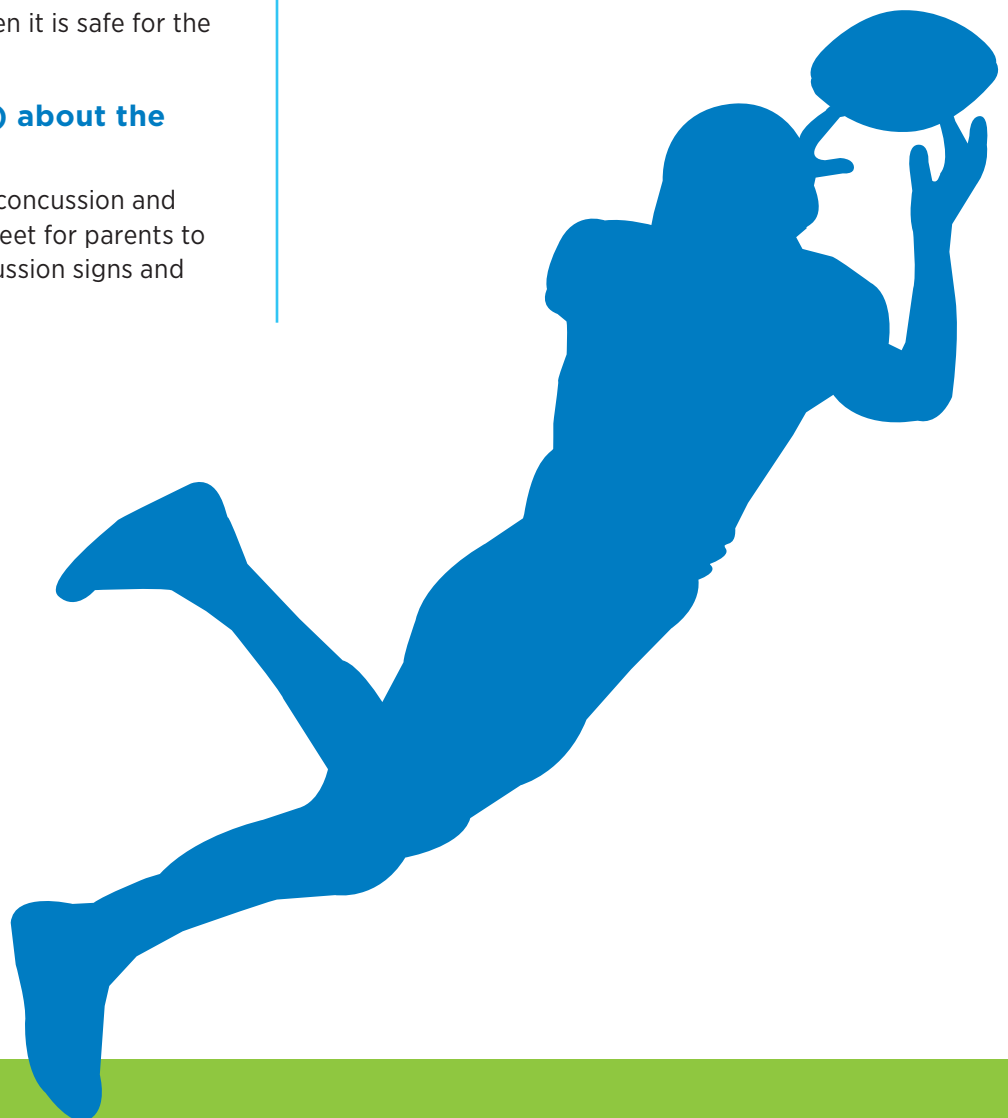
Let parents know about the possible concussion and give them the CDC HEADS UP fact sheet for parents to help them watch the athlete for concussion signs and symptoms at home.

Ask for written instructions from the athlete's healthcare provider on return to play.

This should include information about when the athlete can return to play and steps you should take to help the athlete safely return to play. Athletes who continue to play while having concussion symptoms have a greater chance of getting another concussion. A repeat concussion that occurs before the brain has fully healed can be very serious and can increase the chance for long-term problems. It can even be fatal.

Offer support during recovery.

An athlete may feel frustrated, sad, angry, or lonely while recovering from a concussion. Talk with them about it, and allow an athlete recovering from a concussion to stay in touch with their teammates, such as cheering on their team at practices and competitions.



What steps should I take to help an athlete return to play?

An athlete's return to school and sports should be a gradual process that is approved and carefully managed and monitored by a healthcare provider. When available, be sure to also work closely with your team's certified athletic trainer.

There are six gradual steps to help an athlete safely return to play. These steps should not be done in one day, but instead over days, weeks, or months. **An athlete should move to the next step only if they do not have any new symptoms at the current step.**

Step 1: Return to non-sports activities, such as school, with a greenlight from the healthcare provider to begin the return-to-play process

Step 2: Light aerobic exercise

- Goal: Increase the athlete's heart rate
- Activities: Slow to medium walking or light stationary cycling

Step 3: Sport-specific exercise

- Goal: Add movement
- Activities: Running or skating drills; no activities with risk for contact

Step 4: Non-contact training drills

- Goal: Increase exercise, coordination, and thinking
- Activities: Harder training drills and progressive resistance training

Step 5: Full-contact practice

- Goal: Restore confidence and have coaching staff assess functional skills
- Activities: Normal training activities

Step 6: Return to regular sports activity

Remember: It is important for you and the athlete's parent(s) to watch for concussion symptoms after each day's activities, particularly after each increase in activity. If an athlete's concussion symptoms come back, or if he or she gets new symptoms when becoming more active at any step, this is a sign that the athlete is working too hard. The athlete should stop these activities, and the athlete's parent should contact the healthcare provider. After the athlete's healthcare provider says it is okay, the athlete can begin at the step before the symptoms started.



1. Chrisman SPD, Lowry S, Herring SA, et al. Concussion incidence, duration, and return to school and sport in 5- to 14-year-old American football athletes. *J Pediatr*. 2019;207:176-184. doi:10.1016/j.jpeds.2018.11.003.

2. Guskiewicz KM, McCrea M, Marshall SW, et al. Cumulative effects associated with recurrent concussion in collegiate football players: the NCAA Concussion Study. *JAMA*. 2003;290(19):2549-2555.

3. Collins CL, Fields SK, Comstock RD. When the rules of the game are broken: what proportion of high school sports-related injuries are related to illegal activity? *Inj Prev*. 2008;14(1):34-38.

4. Rivara FP, Schiff MA, Chrisman SP, Chung SK, Ellenbogen RG, Herring SA. The effect of coach education on reporting of concussions among high school athletes after passage of a concussion law. *Am J Sports Med*. 2014;42(5):1197-1203.

5. Kerr ZY, Register-Mihalik JK, Marshall SW, Evenson KR, Mihalik JP, Guskiewicz KM. Disclosure and non-disclosure of concussion and concussion symptoms in athletes: review and application of the socio-ecological framework. *Brain Inj*. 2014;28(8):1009-1021.

6. Register-Mihalik JK, Guskiewicz KM, McLeod TC, Linnan LA, Mueller FO, Marshall SW. Knowledge, attitude, and concussion-reporting behaviors among high school athletes: a preliminary study. *J Athl Train*. 2013;48(5):645-653.

7. Chrisman SP, Quitiquit C, Rivara FP. Qualitative study of barriers to concussive symptom reporting in high school athletics. *J Adolesc Health*. 2013;52(3):330-335.

The information provided in this fact sheet or through linkages to other sites is not a substitute for medical or professional care. Questions about diagnosis and treatment for concussion should be directed to a physician or other healthcare provider.

Revised August 2019

To learn more,
go to cdc.gov/HEADSUP





A PARENT'S / GUARDIAN'S GUIDE TO CONCUSSION

National Federation of State High School Associations (NFHS)
Sports Medicine Advisory Committee (SMAC)

What is a concussion?

- A concussion is a traumatic brain injury that interferes with the normal function of the brain. Concussions were previously referred to as a “ding” or a “bell-ringer” but this undermines the seriousness of problem. Any suspected concussion must be taken very seriously. An athlete does not need to lose consciousness (be “knocked-out”) to suffer a concussion. In fact, less than 5% of concussed athletes suffer a loss of consciousness.

Concussion Facts

- Structural injuries, like torn ligaments and broken bones, can be seen on an x-ray or on scans like an MRI. On the other hand, a concussion is a disruption of how the brain works, or its function, and not in its structure. That is why CT scans and MRIs are of limited value. The injury affects the way the brain works, not how it looks.
- It is estimated that approximately 1.1 million to 1.9 million recreational concussions and sports related concussions occur annually in the United States in children 18 years of age or younger. In nine popular high school sports alone, well over 200,000 concussions are sustained by high school athletes each year. (Halstead ME, et.al.)
- Concussions can happen in any sport. While they are more common in sports that involve collisions, athletes in all sports are at risk for a concussion. When researchers looked at 14 different high school sports, they found that over two-thirds of concussions result from contact with another athlete and the second leading cause of concussion, is player-to-surface contact. This includes falling and hitting the ground.
- An athlete may report many physical, behavioral, and cognitive symptoms. Physical symptoms include headaches, nausea, vomiting, dizziness, and sleep changes. Some behavioral changes include irritability, anxiety, and depression. Cognitive symptoms are changes in the way we think and include feeling sluggish, hazy, or foggy, difficulty falling asleep or staying asleep, difficulty concentrating or memory problems, and confusion.
- Many symptoms appear immediately after the injury, while others may develop over the next several days. The symptoms can interfere with normal daily life in addition to difficulty with school, work, and social life.
- Concussion symptoms typically resolve within one week to one month. It is important to remember that each student athlete responds and recovers differently.
- Athletes should not return to sports or activities that will put them at risk for another head injury until the concussion has completely resolved. To do so puts them at risk for worsening and prolonged symptoms and a more severe injury. While rare, a repeat concussion can also result in severe swelling and bleeding in the brain. This condition can lead to death or permanent disability.

What should I do if I think my child has had a concussion?

If your child sustains a head injury, it is good to be aware of the signs and symptoms of a concussion. If you suspect an athlete has a concussion, the athlete must be immediately removed from activity. Do not allow the athlete to drive until symptoms have resolved. Continuing to participate in a contact or collision sport while experiencing concussion symptoms can lead to worsening of symptoms, increased risk for further injury and sometimes death.

Parents and coaches should not make the diagnosis of a concussion. Any athlete suspected of having a concussion should be evaluated by a medical professional trained in the diagnosis and management of concussions.

When in doubt, sit them out!

All athletes who sustain a concussion need to be evaluated by an appropriate health-care professional, who is experienced in concussion management. If your child's school has an athletic trainer (AT), please inform the AT of your concerns. You should also call your child's primary care provider and explain what has happened and follow the instructions you are given. Sometimes, an injury is more severe than it appears. If your child has persistent vomiting, a worsening headache, a seizure, or is acting differently, you should take your child to an emergency department for immediate attention.

What are the signs and symptoms of a concussion?

SIGNS OBSERVED BY PARENTS, ATHLETIC TRAINERS, FRIENDS, TEACHERS OR COACHES

- Dazed, vacant or stunned appearance.
- Confusion about assignment or position.
- Forgetfulness.
- Uncertainty of game, score, or opponent.
- Clumsy movements.
- Slow response to questions.
- Mood, behavior or personality changes.
- Can't recall events prior to or after hit or fall.

SYMPTOMS REPORTED BY ATHLETE

- Headache or "pressure" in head.
- Neck pain
- Balance problems or dizziness
- Nausea
- Double or blurry vision
- Sensitivity to light or noise
- Feeling sluggish, hazy, or mentally foggy
- Concentration or memory problems
- Confusion
- "Not feeling right" or "feeling down"

How can a concussion affect schoolwork?

Following a concussion, many students have difficulty in school due to difficulties with short-term memory, concentration, and organization.

In many cases after the injury, it is best to decrease the athlete's class load early in the recovery phase. This may include staying home from school for no more than 1 or 2 days, followed by academic adjustments (such as a reduced class schedule, extended time to complete assignments, printed notes, delayed testing, etc.), until the athlete has fully recovered. Decreasing the stress on the brain and not allowing the athlete to push through symptoms will shorten the recovery time and ensure total resolution of symptoms. The academic adjustments are best managed by a school concussion team. Speak with the school guidance counselor, school nurse, or athletic trainer to help with this process.

Return-to-Learn (RTL)

Facilitating return-to-learn is a vital part of the recovery process for student athletes. The return-to-learn process should be individualized and include a plan for return to the classroom / studying as tolerated. The majority of athletes of all ages have a full return-to-learn with no additional academic support by 10 days. Return-to-learn participation after sport-related concussion follows a graduated stepwise strategy as outlined in **Table 1**: Return-to-learn (RTL) strategy:

Table 1 Return-to-learn (RTL) strategy			
Step	Mental activity	Activity at each step	Goal
1	Daily activities that do not result in more than a mild exacerbation* of symptoms related to the current concussion	Typical activities during the day (eg, reading) while minimising screen time. Start with 5–15 min at a time and increase gradually.	Gradual return to typical activities
2	School activities	Homework, reading or other cognitive activities outside of the classroom.	Increase tolerance to cognitive work
3	Return to school part time	Gradual introduction of schoolwork. May need to start with a partial school day or with greater access to rest breaks during the day.	Increase academic activities
4	Return to school full time	Gradually progress in school activities until a full day can be tolerated without more than mild* symptom exacerbation.	Return to full academic activities and catch up on missed work
Following an initial period of relative rest (24–48 hours following an injury at Step 1), athletes can begin a gradual and incremental increase in their cognitive load. Progression through the strategy for students should be slowed when there is more than a mild and brief symptom exacerbation. *Mild and brief exacerbation of symptoms is defined as an increase of no more than 2 points on a 0–10 point scale (with 0 representing no symptoms and 10 the worst symptoms imaginable) for less than an hour when compared with the baseline value reported prior to cognitive activity.			

Patricios JS, et.al.

When can an athlete return to sport following a concussion?

After suffering a concussion, or if you suspect an athlete has a concussion, **no athlete should EVER return to sport or practice on that same day.**

Return-to-Sport (RTS)

Athletes should be allowed to engage in activities of daily living (including walking) immediately following injury, even during the initial period of 24-48 hours of relative rest. Athletes may begin Step 1 (i.e., symptom-limited activity) within 24 hours of injury, with progression through each subsequent step typically taking a minimum of 24 hours. Progression through the later Return-to-Sport strategy (Steps 4-6) should be monitored by a health care provider. Return-to-sport participation after sport-related concussion follows a graduated stepwise strategy, as outlined in **Table 2**:

Table 2 Return-to-sport (RTS) strategy—each step typically takes a minimum of 24 hours

Step	Exercise strategy	Activity at each step	Goal
1	Symptom-limited activity	Daily activities that do not exacerbate symptoms (eg, walking).	Gradual reintroduction of work/school
2	Aerobic exercise 2A—Light (up to approximately 55% maxHR) then 2B—Moderate (up to approximately 70% maxHR)	Stationary cycling or walking at slow to medium pace. May start light resistance training that does not result in more than mild and brief exacerbation* of concussion symptoms.	Increase heart rate
3	Individual sport-specific exercise Note: If sport-specific training involves any risk of inadvertent head impact, medical clearance should occur prior to Step 3	Sport-specific training away from the team environment (eg, running, change of direction and/or individual training drills away from the team environment). No activities at risk of head impact.	Add movement, change of direction
Steps 4–6 should begin after the resolution of any symptoms, abnormalities in cognitive function and any other clinical findings related to the current concussion, including with and after physical exertion.			
4	Non-contact training drills	Exercise to high intensity including more challenging training drills (eg, passing drills, multiplayer training) can integrate into a team environment.	Resume usual intensity of exercise, coordination and increased thinking
5	Full contact practice	Participate in normal training activities.	Restore confidence and assess functional skills by coaching staff
6	Return to sport	Normal game play.	

*Mild and brief exacerbation of symptoms (ie, an increase of no more than 2 points on a 0–10 point scale for less than an hour when compared with the baseline value reported prior to physical activity). Athletes may begin Step 1 (ie, symptom-limited activity) within 24 hours of injury, with progression through each subsequent step typically taking a minimum of 24 hours. If more than mild exacerbation of symptoms (ie, more than 2 points on a 0–10 scale) occurs during Steps 1–3, the athlete should stop and attempt to exercise the next day. Athletes experiencing concussion-related symptoms during Steps 4–6 should return to Step 3 to establish full resolution of symptoms with exertion before engaging in at-risk activities. Written determination of readiness to RTS should be provided by an HCP before unrestricted RTS as directed by local laws and/or sporting regulations.

HCP, healthcare professional; maxHR, predicted maximal heart rate according to age (ie, 220-age).

Patricios JS, et.al.

Progression through the strategy is symptom limited (ie, no more than a mild and brief exacerbation of current symptoms related to the current concussion) and its course may vary across individuals based on tolerance and symptom resolution. Further, while the return-to-learn and return-to-sport strategies can occur in parallel, student-athletes should complete full return-to-learn before unrestricted return-to-sport.

Concerns over athletes returning to sport too quickly led lawmakers in all 50 states and the District of Columbia to pass laws stating that **no player shall return to sport or practice the day of a concussion, and the athlete must be cleared by an appropriate health-care professional before being allowed to return to sport in either games or practices.** Many of these laws require players, parents and coaches to receive education on the dangers of concussion in addition to recognizing the signs and symptoms of concussion.

What can I do?

- ☐ Both you and your child should learn to recognize the “Signs and Symptoms” of concussion as listed above.
- ☐ Encourage your child to tell the medical and/or coaching staff if any of these signs and symptoms appear after a blow to the head or body.
- ☐ Emphasize to administrators, coaches, physicians, athletic trainers, teachers and other parents your concerns and expectations about concussion and safe play.
- ☐ Encourage your child to tell the medical and coaching staff if there is suspicion that a teammate has suffered a concussion.
- ☐ Ask teachers to monitor any decrease in grades or changes in behavior in students that could indicate a concussion.
- ☐ Report concussions that occurred during the school year to appropriate school staff. This will help in monitoring injured athletes as they move to the next season’s sports.

Click here for more information about returning to school after a concussion:

http://www.cdc.gov/headsup/basics/return_to_school.html

Other Frequently Asked Questions:

Why is it so important that athletes not return to sport until they have completely recovered from a concussion?

Students that return to sport too soon may worsen concussion symptoms, prolong the recovery time, and they also risk catastrophic consequences if they suffer another head injury. These consequences are preventable if each athlete is allowed time to recover from their concussion including completing the stepwise return-to-sport protocol. No athlete should return to sport or other at-risk activity when signs or symptoms of concussion are present and recovery is ongoing.

Is a CT scan or MRI needed to diagnose a concussion?

No! The diagnosis of a concussion is based upon the athlete's history of the injury and an appropriate health-care professional's physical examination and testing. CT and MRI scans are rarely needed following a concussion since this is a functional injury and not a structural one. However, they are helpful in identifying life-threatening head and brain injuries such as skull fractures, bleeding or swelling.

What is the best treatment to help my child recover quickly from a concussion?

The first step in recovering from a concussion is relative rest. Rest is essential to help the brain heal. Athletes with a concussion need rest from physical and mental activities that require concentration and attention as these activities may worsen symptoms and delay recovery. Exposure to loud noises, bright lights, computers, video games, television and phones all may worsen the symptoms of concussion. Athletes typically require 24-48 hours of *relative rest*, which include activities of daily living and reduced screen time. Individuals can return to light-intensity physical activity, such as walking that does not more than mildly exacerbate symptoms, during the initial 24-48 hours following a concussion. After the initial 24-48 hours begin gradually increasing mental and physical activity as tolerated. Early aerobic exercise can help speed recovery.

There are no medications to treat concussions, but an appropriate health-care professional may prescribe medications and therapies to treat symptoms of a concussion, such as headache, dizziness, sleep changes, etc. Some athletes may require rehabilitation, such as physical, occupational, vestibular, ocular or speech/cognitive therapy. Others may require treatment for mood and behavior changes. All of these interventions are done on a personalized basis.

How long do the symptoms of a concussion usually last?

Typically, athletes can expect a minimum of 1 week to complete the full rehabilitation strategy; however, unrestricted return-to-sport can take up to 1 month following a sports related concussion, with an estimated average of 20 days. Progression through the strategy is symptom limited (ie, no more than a mild and brief exacerbation of current symptoms related to the current concussion) and its course may vary across individuals based on tolerance and symptom resolution. Further, while the return-to-learn and return-to-sport strategies can occur in parallel, student-athletes should complete full return-to-learn before unrestricted return-to-sport.

How many concussions can an athlete have before we should consider retiring from playing sports?

There is no "magic number" of concussions that determine when an athlete should give up playing sports that put one at high risk for a concussion. The circumstances that surround each individual injury, such as how the injury occurred as well as the number and duration of symptoms following the concussion, are very important.

These circumstances must be individually considered when assessing an athlete’s risk for potential long-term consequences and potentially more serious brain injuries. The decision to “retire” from sports is a decision best reached after a complete evaluation by your child’s primary care provider and consultation with an appropriate health-care professional who specializes in treating concussions.

We cannot eliminate all of the risk of concussion from sports. However, we can take what we learn from science to reduce the chance for injury and set policy to ensure that students with a concussion get the care they need.

Everyone involved in high school sports plays an active role in educating others about concussion and other serious brain injuries. Please check out the Resource section on the Sports Medicine page of the NFHS Website for more information on how you can take an active role and get involved in keeping students safe, healthy and active.

Some of this information has been adapted from the CDC’s “Heads Up: Concussion in High School Sports” materials by the NFHS’s Sports Medicine Advisory Committee. Please go to www.cdc.gov/ncipc/tbi/Coaches_Tool_Kit.htm for more information.

References:

1. Halstead ME, Walter KD, Moffatt K; COUNCIL ON SPORTS MEDICINE AND FITNESS. [Sport-Related Concussion in Children and Adolescents](#). *Pediatrics*. 2018 Dec;142(6). pii: e20183074. doi: 10.1542/peds.2018-3074. Epub 2018 Nov 12.
2. Patricios JS, Schneider KJ, Dvorak J, Ahmed OH, Blauwet C, Cantu RC, Davis GA, Echemendia RJ, Makdissi M, McNamee M, Broglio S, Emery CA, Feddermann-Demont N, Fuller GW, Giza CC, Guskiewicz KM, Hainline B, Iverson GL, Kutcher JS, Leddy JJ, Maddocks D, Manley G, McCrea M, Purcell LK, Putukian M, Sato H, Tuominen MP, Turner M, Yeates KO, Herring SA, Meeuwisse W. Consensus statement on concussion in sport: the 6th International Conference on Concussion in Sport-Amsterdam, October 2022. *Br J Sports Med*. 2023 Jun;57(11):695-711. doi: 10.1136/bjsports-2023-106898. PMID: 37316210.

October 2023

April 2019

April 2016

April 2013

April 2010

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WVSSAC First Aid & CPR Training

**All Coaches are requires
to be trained.....**

- ✓ First Aid Training
- ✓ CPR & AED Training
- ✓ Emergency Response

***An AED MUST be available at all
practice and contests.**



Our Website Resources
www.wvssac.org/sports-medicine/





WEST VIRGINIA

Secondary School Activities Commission

2875 STAUNTON TURNPIKE PARKERSBURG, WV 26104
(304) 485-5494

Body Fluid Standard Precautions

PURPOSE

The West Virginia Secondary School Activities Commission has adopted this policy in an effort to minimize the possibility of transmission of any infectious disease during a high school athletic practice or contest. The policy primarily addresses blood-borne pathogens such as Hepatitis B virus and the Human Immunodeficiency Virus (HIV). However, it also discusses common-sense precautions against the spread of less serious contagions such as the Influenza virus and the Common Cold virus.

Much of this policy has been written with contact sports such as football, wrestling, and basketball in mind. However, it is applicable for all sports.

BLOOD-BORNE PATHOGENS

Blood-Borne pathogens such as Hepatitis B and HIV are serious infectious diseases which are present in blood as well as other bodily fluids; such as semen, vaginal secretions and breast milk. While there are a number of other such blood-borne diseases, Hepatitis B and HIV are the most commonly known.

Hepatitis B is a virus which results in a dangerous inflammation of the liver. Its victims suffer long-term consequences and reoccurrences, and the disease can be deadly if not treated. HIV is the virus that causes Acquired Immunodeficiency Syndrome (AIDS), which weakens the immune system, thus making a person susceptible to infections their immune systems would normally fight off.

The precise risk of HIV transmission during exposure of open wounds or mucous membranes such as the eyes, ears, nose, and mouth to contaminated blood is not known. However, evidence would suggest it is extremely low. In fact, the possibility of contracting HIV in this manner is much less than the possibility of contracting Hepatitis B and other blood-borne viral infections.

Therefore, student athletes, coaches, and officials must understand that while it is possible for HIV to be transmitted by blood from one individual to another through an open wound or a mucous membrane, the probability is very low. However, since the chance of this occurring is not zero, appropriate precautions should be taken to ensure no transmission can occur.

PRECAUTIONS AGAINST TRANSMISSION OF BLOOD-BORNE PATHOGENS

The proper handling of body fluid spills should be a concern of teachers, coaches, officials, and student athletes. All concerned individuals must be aware that any time there is blood and/or other body fluids present, there is the possibility of an infectious disease being present. However, this possibility can be nearly eliminated if the following precautions are observed.

General Procedures:

1. Wear latex or vinyl disposable exam gloves before making contact with body fluids during care, treatment, and cleaning procedures.
2. Discard gloves after each use.
3. Wash hands after handling any body fluids, whether or not gloves are worn.
4. Discard disposal items in plastic lined containers with lids. Close bags and discard daily.
5. Do not reuse plastic bags.
6. Use disposable items to handle body fluids whenever possible.
7. Use paper towels to pick up and discard any solid waste materials such as vomitus and feces.

Procedures for Activities:

1. All athletes must cover any open wound.
2. Student athletes should treat and cover their own wounds whenever possible.
3. When administering first aid, disposable latex or vinyl gloves should be worn. A different pair of gloves should be worn for each treatment administered.
4. If an individual gets someone else's blood on his/her skin, the area should be washed with soap and water and wipe the area with disinfectants, such as isopropyl alcohol.
5. If a student athlete begins to bleed during activity, play must be stopped, the student athlete who is injured removed, and any potentially contaminated surfaces cleaned using a disinfectant. The surface should be wiped with clean water.
6. Any student athlete that is removed must have the wound covered and the bleeding stopped, prior to returning to contest.
7. Any individual who has treated a wound or cleaned a contaminated surface should wash his/her hands with soap and warm water.
8. A student athlete should take a shower using a liberal amount of soap and warm water following the contest.
9. Towels, which are used by athletes, coaches, or officials, should not be used to clean off any potentially contaminated surfaces.
10. All soiled linens such as towels and uniforms should be washed in hot water and in a detergent containing bleach, if possible.
11. If a coach or an official gets blood on them, they should first wash the area with warm water and soap and then wipe the area with a disinfectant such as isopropyl alcohol.
12. All coaches, athletes, and officials should practice good hygiene. Towels, cups, and water bottles should not be shared.
13. Keeping locker rooms and other areas well-ventilated and clean can also help in preventing other air-borne contagions from being transmitted.

REFERENCES

St. Joseph's Hospital, Sports Medicine Staff, Parkersburg, WV.

West Virginia Chapter of the American Academy of Family Physicians, Sports Medicine Committee. "Blood-Borne Pathogens in the Health Care of the Athlete," The First Aider. Fall 1992, Vol. 62, No.1. "Infectious Disease Policy of the Florida High School Activities Association." 8-8-92.

"Routine for Handling Body Fluids," Michigan High School Association.

Policy Adopted by the Board of Directors



Sports-Related Skin Infections

Position Statement and Guidelines

National Federation of State High School Associations (NFHS) Sports Medicine Advisory Committee (SMAC)

Skin-related infections in both the community setting and the sports environment have increased considerably over the past several years. While the majority of these infections are transmitted through skin-to-skin contact, a significant number are due to shared equipment, towels or poor hygiene in general. The NFHS Sports Medicine Advisory Committee (SMAC) has put forth general guidelines for the prevention of the spread of these infectious diseases (See NFHS General Guidelines for Sports Hygiene, Skin Infections and Communicable Diseases).

The NFHS SMAC recognizes that even with strict adherence to these guidelines, given the nature of certain sports, skin infections will continue to occur. For example, the risk of transmission is much higher in sports with a great deal of direct skin-to-skin contact such as wrestling and football. Therefore, the NFHS SMAC has developed specific guidelines for the skin infections most commonly encountered in sports. The guidelines set forth follow the principles of Universal Precautions and err in favor of protecting participants in situations where skin-to-skin contact may occur. Consideration may be given to the particular sport regarding risk of transmission, but these guidelines must be strictly adhered to in sports where skin-to-skin contact is frequent and unavoidable.

Tinea Corporis (ringworm), Tinea Capitis (scalp), Tinea Cruris (groin)

These fungal lesions are due to dermatophytes. Diagnosis can be made visually or by a KOH preparation if diagnosis is in question. As they are easily transmissible, the student should be treated with topical antifungal medication (terbinafine or naftidine) for a minimum of 72 hours prior to participation and a minimum of 1 week after lesion resolution. Persistent lesions require oral anti-fungal medications. Once the lesion is considered to be no longer contagious, it may be covered with a bio-occlusive dressing. For scalp involvement (Tinea Capitis), the infection is more difficult to treat and requires 14 days of oral antifungal medication before return to practice and competition. With scalp involvement, shedding of fungal spores can persist well beyond 2 weeks. Consider washing scalp before practice with ketoconazole 1% shampoo to reduce transmission of spores. Continue with treatment until scalp lesions are gone. Tinea Cruris is a groin infection. Treatment with a topical antifungal until resolution is usually adequate. As lesion is covered by the uniform no exclusion from participation is indicated. Athletes should be reminded to wash hands with soap and water after applying medication.

Impetigo, Folliculitis, Carbuncle and Furuncle

While these infections may be secondary to a variety of bacteria, methicillin-resistant *Staphylococcus aureus* (MRSA) infections are of greatest concern. MRSA presents as abscess formation and if not properly

addressed, can lead to serious consequences and possible reoccurrence. An infected athlete should be treated and removed from practice and competition. Treatment may consist of incision and drainage with appropriate oral antibiotics based on culture if available. If MRSA is present, abscess incision and drainage is recommended for return to practice and competition may be considered after 72 hours of treatment, provided there is no further drainage or new abscess formation. For non-MRSA infections, return to contact practices and competition may occur after 72 hours of treatment, provided the infection is not actively draining and being treated. At this time the involved site may be covered with a bio-occlusive dressing. All lesions should be considered infectious until each one has a well-adherent scab without any drainage or weeping fluids. Once a lesion is no longer considered infectious, it should be covered with a bio-occlusive dressing until complete resolution.

During the time when a student has been identified with any of these infections, increased screening should occur. At this time, all team members should be carefully screened for similar infections on a daily basis by a knowledgeable coach or appropriate health-care professional. If multiple students are infected, consideration should be given to contacting the local or state health department for further guidance.

Varicella/Zoster (shingles), Herpes Simplex (HSV1 , cold sore, fever blister)

These are viral infections, which are transmitted by skin-to-skin contact. Contact with fluid from a shingles lesion can cause varicella (chickenpox) in an individual who has never had chickenpox or the varicella vaccine. Fever blisters (cold sores) are HSV1 infections around the mouth and lips. Lesions on exposed areas of skin that are not covered by clothing or uniform require the player to be withdrawn from any activity that may result in direct skin-to-skin contact with another participant. Covering infectious lesions with an occlusive dressing is not adequate, sufficient, or acceptable. Prior to returning to participation, primary outbreaks of shingles and cold sores require 10-14 days of oral antiviral medications, while recurrent outbreaks require 120 hours of treatment as a minimum treatment time. For a student to be considered “non-contagious,” all lesions must be scabbed over with no oozing or discharge, no new lesions should have occurred in the preceding 72 hours, and no systemic symptoms (fever, malaise).

Herpes Gladiatorum

This skin infection, primarily seen among wrestlers, is caused by herpes simplex virus Type 1 (HSV-1). The spreading of this virus is strictly skin-to-skin. The majority of the outbreaks develop on the head, face and neck, reflecting the typical wrestling lock-up position. The initial outbreak is characterized by a raised rash with groupings of 6-10 vesicles (blisters). For head, face and neck involvement, symptoms include sore throat, fever, malaise and swollen cervical lymph nodes. The infected individual must be immediately removed from contact (practices and contests) and seek appropriate care and treatment. Return to contact is permissible only after all lesions are healed with well-adherent scabs, no new vesicles have formed, and no swollen lymph nodes remain near the affected area. Oral antiviral medications should be started and can expedite the clearing of an outbreak. Careful consideration should be given to prophylactic oral antivirals for the remainder of the season and each subsequent season. For a primary infection (first episode of Herpes Gladiatorum), wrestlers should be treated and not allowed to practice or compete for a minimum of 10 days. If general body signs and symptoms like fever and swollen lymph nodes are present, that minimum period of treatment should be extended to 14 days. If antivirals are not used, the infected participant may return to full contact wrestling only after all lesions are well-healed with well-adhered scabs, there has been no new vesicle formation in the preceding 72 hours, and there are no swollen lymph nodes near the affected area.

Recurrent outbreaks usually involve a smaller area of skin, milder systemic illness and a shorter duration of symptoms. Treatment should include oral antivirals. If antiviral therapy is initiated, the participant must be held from contact sports for a minimum of 120 hours. Even greater consideration should be given to prophylactic antivirals for the remainder of the season. As the herpes virus may spread prior to vesicle formation, anyone in contact with the infected individual during the three days prior to the outbreak **must** be isolated from any contact activity for eight days and be examined daily by a knowledgeable coach or appropriate health-care professional for suspicious skin lesions.

Miscellaneous Viral Infections

Verrucae (warts) are skin infections that are also caused by viruses but are not considered highly contagious. Therefore, these lesions require no treatment or restrictions, but should be covered if prone to bleeding when abraded. Molluscum contagiosum is considered contagious and transmits via direct skin-to-skin contact. Treatment consists of expressing the material from each vesicle and lightly treating with a hyfrecator or cryotherapy, usually performed by an appropriate health-care professional. Participation can ensue immediately after treatment, provided sites are covered with a bio-occlusive dressing.

April 2025

2022

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2016

2013

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PROTECT YOURSELF

How to Avoid Common Skin Conditions in Sports

Skin diseases are common among athletes for several reasons, including environmental factors, trauma to the skin, close quarters and sometimes questionable hygiene practices. There are three types of skin diseases: fungal, viral and bacterial. If you suspect you or someone else has a skin infection, see a physician for treatment options as soon as possible.

FUNGAL INFECTIONS

Caused by dermatophytes—fungal organisms that live in soil and on animals and humans.

Tinea capitis: A fungal infection of the scalp that looks like gray, scaly patches and can be accompanied by mild hair loss.

Tinea corporis (aka "ring worm"): A fungal infection of the body that features a ring-like appearance.

Tinea cruris (aka "jock itch"): A fungal infection of the groin area consisting of well-defined red patches.

Tinea pedis (aka "athlete's foot"): A fungal infection of the feet that has the appearance of red scales.

VIRAL INFECTIONS

Caused by the herpes simplex virus and molluscum contagiosum virus.

Herpes simplex virus: A painful recurring infection consisting of clusters of small fluid-filled sacs on a base of red skin.

Molluscum contagiosum: A highly infectious viral disease caused by the poxvirus that features smooth flesh-colored, dome-shaped bumps with a depression in the center.

BACTERIAL INFECTIONS

Caused by various gram-positive strains of streptococcus and staphylococcus aureus (staph a.) bacteria.

Impetigo: A bacterial infection caused by staph a. commonly affecting the face. It consists of thin-walled sacs of fluid that rupture into a honey-colored crust.

Folliculitis: A superficial infection of the hair follicles characterized by redness, fluid- or pus-filled sacs at the base of hair follicles.

Furunculosis: A deeper infection of the hair follicle characterized by inflamed nodules that drain fluid.

Carbuncles: When furunculosis nodules join together to form larger nodules.

Methicillin resistant staphylococcus aureus (MRSA):

A strain of staph a. that has acquired a specific gene, making it resistant to common antibiotic therapy. It has the appearance of any other bacterial infection with small pustules and abscesses, and is commonly confused for a spider bite.

MRSA is highly infectious and anyone suspected of having a MRSA infection should immediately be isolated and seen by a physician.

SKIN DISEASE PREVENTION BASICS

Follow good hygiene practices, such as frequently washing hands or showering after every sports activity.



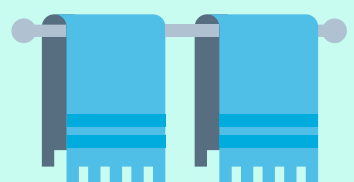
Wash hands and body with antimicrobial soap.



Refrain from cosmetic body shaving.



Don't share towels, athletic gear, water bottles, disposable razors or hair clippers.



Launder and/or disinfect all clothing and sports equipment daily.



Avoid whirlpools and common tubs if you have an open wound, scrape or scratch.



Inspect your skin daily and report any suspicious areas to your athletic trainer or physician. This includes abrasions, cuts and skin lesions.



PREVENT SKIN INFECTIONS: A PLAYERS GUIDE

1

Cover Cuts & Sores

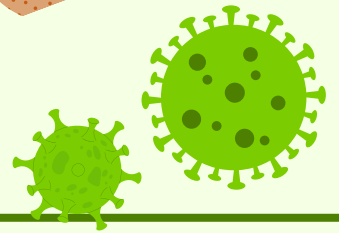
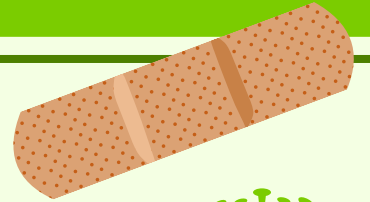
With a bandaid or wrap before you play



Wash Up!

With soap and hot water

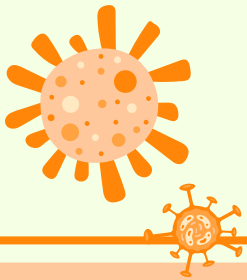
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3

Don't Share

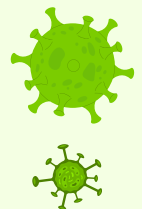
Towels, clothes or personal items



Show & Tell !

Show cuts and sores to your coach

4



5

Be Prepared !

Learn first aid for cuts and sores



GENERAL GUIDELINES FOR SPORTS HYGIENE, SKIN INFECTIONS AND COMMUNICABLE DISEASES

**National Federation of State High School Associations (NFHS)
Sports Medicine Advisory Committee (SMAC)**

Proper precautions are needed to minimize the potential risk of the spread of communicable disease and skin infections during athletic competition. These conditions include skin infections that occur due to skin contact with competitors and equipment. The transmission of infections such as Methicillin-Resistant Staphylococcus aureus (MRSA) and Herpes Gladiatorum, blood-borne pathogens such as HIV and Hepatitis B, and other infectious diseases such as Influenza and COVID-19 can often be greatly reduced through proper hygiene. The NFHS SMAC has outlined and listed below some general guidelines for the prevention of the spread of these diseases.

Universal Hygiene Protocol for All Sports:

- Shower immediately after every competition and practice, using liquid soap and not a shared bar soap. If not immediately available, consider using soap and water wipes to cleanse all exposed body surfaces to reduce the presence of infectious agents.
- Wash all workout clothing after each practice, washing in hot water and drying on a high heat setting.
- Clean and/or wash all personal gear (knee pads, head gear, braces, etc.) and gym bags at least weekly.
- Do not share towels or personal hygiene products (razors) with others.
- Refrain from full body and/or cosmetic shaving of head, chest, arms, legs, abdomen, and groin.
- Students should clean hands with an alcohol-based gel or soap and water before and after every practice and contest to decrease bacterial load on the hands.
- Covering up coughs and sneezes in the bend of the elbow instead of the hand
- Stay home from school and athletic participation if frequent cough, diarrhea, vomiting, or fever.

Infectious Skin Diseases

Strategies for reducing the potential exposure to these infectious agents include:

- Students must notify a parent/guardian and coach of any skin lesion prior to any competition or practice. An appropriate health-care professional must evaluate all concerning skin lesions before returning to practices or competition.
- If an outbreak occurs on a team, especially in a contact sport, all team members should be evaluated to help prevent the potential spread of the infection. All shared equipment shall be properly cleaned/disinfected prior to use.

- Coaches, officials, and appropriate health-care professionals must follow NFHS or state/local guidelines on “time until return to competition.” Participation with a covered lesion may be considered if in accordance with NFHS, state or local guidelines and the lesion is no longer contagious.

Blood-borne Infectious Diseases

Strategies for reducing the potential exposure to these agents include following Universal Precautions such as:

- A student who is bleeding, has an open wound, has any amount of blood on a uniform, or has blood on their body, shall be directed to leave the activity (game or practice) until the bleeding is stopped, the wound is covered, the uniform and/or body is appropriately cleaned, and/or the uniform is changed before returning to activity.
- Athletic trainers, coaches, referees or other caregivers must wear gloves and use Universal Precautions to prevent blood or body fluid-splash from contaminating themselves or others.
- In the event of a blood or body fluid-splash, immediately wash contaminated skin or mucous membranes with soap and water. Skin antiseptics (e.g., isopropyl alcohol) or moist towelettes may be used if soap and water not available.
- Clean all contaminated surfaces and equipment with disinfectant before returning to competition. Be sure to use gloves when cleaning.
- Blood on an opponent’s uniform during competition or teammate’s uniform during practice should be cleaned at that time by wiping with a disinfectant such as isopropyl alcohol.
- Any blood exposure or bites to the skin that break the surface must be reported and immediately evaluated by an appropriate health-care professional.

Other Communicable Diseases

Means of reducing the potential exposure to these agents include:

- Make certain that students, coaching staff, and medical staff are current on all required vaccinations (MMR, Hepatitis B, Chickenpox, Meningitis, Hepatitis A). COVID-19 vaccine and yearly influenza vaccine are strongly encouraged.
- During times of outbreaks, follow the guidelines set forth by the CDC as well as State and local Health Departments.

April 2025

2022

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TAKING THE STING OUT OF SKIN INJURIES

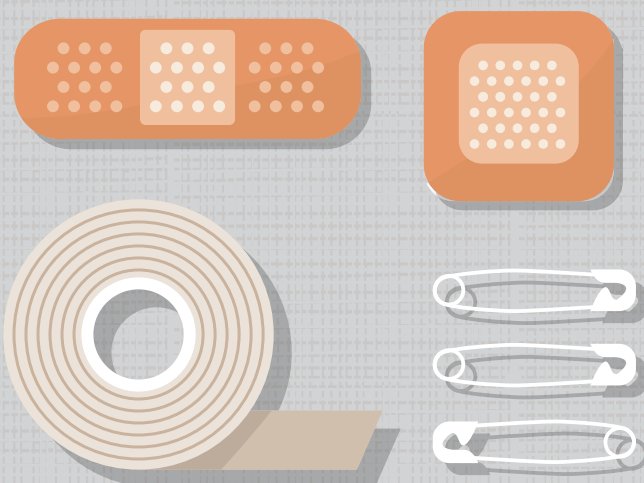
Common skin injuries in sports include: lacerations, incisions, blisters, abrasions, avulsions and punctures. When properly treated, an acute skin injury will heal faster with decreased risk of infection and adverse reactions.

CARING FOR SKIN INJURIES

See a physician as soon as possible if the wound is deep and requires sutures or staples, is heavily contaminated, involves tendon or nerve injury, becomes warm, develops drainage, is painful, forms a rash or is slow to heal.

CLEANING AND DRESSING

- + Clean the wound and surrounding skin thoroughly with saline or tap water irrigation as soon as possible.
- + Don't scrub or swab the wound since this won't reduce bacteria and can damage healing skin.
- + Be cautious when using antiseptics to clean wounds as they can be toxic to skin tissue.
- + After the initial cleaning, the wound should only be cleaned if it becomes visibly contaminated or infected.
- + Any debris should be removed prior to dressing the wound.
 - A health care provider, such as an athletic trainer, should debride the wound if there are large amounts of debris.
- + The wound should be covered, rather than left uncovered, until fully healed.
- + Cover the wound with nonocclusive dressings (sterile gauze, nonadherent pads, adhesive strips and patches) or occlusive dressings (films, foams and hydrocolloids). Occlusive dressings, available at pharmacies, are preferred since they create an optimal healing environment.



AFTER CARE AND FOLLOW-UP

- + Monitor for signs of infection:
 - Fever, pain, edema, warmth or delayed wound healing
- + Monitor for adverse reactions that can come from some cleaning solutions, topical antimicrobial agents and dressings:
 - Rash, white discoloration, tenderness or a burning sensation
- + Have the wound area inspected by an athletic trainer or sports medicine provider daily throughout the healing process to ensure it's properly healing and dressed.

CDC - RECOMMENDATIONS FOR SCHOOL ATHLETIC TEAMS

01

COVER ALL WOUNDS. IF A WOUND CANNOT BE COVERED ADEQUATELY, CONSIDER EXCLUDING PLAYERS WITH POTENTIALLY INFECTIOUS SKIN LESIONS FROM PRACTICE OR COMPETITIONS UNTIL THE LESIONS ARE HEALED OR CAN BE COVERED ADEQUATELY.

02

ENCOURAGE GOOD HYGIENE, INCLUDING SHOWERING AND WASHING WITH SOAP AFTER ALL PRACTICES AND COMPETITIONS

03

ENSURE AVAILABILITY OF PROPER SOAP AND HOT WATER

04

DISCOURAGE SHARING OF TOWELS AND PERSONAL ITEMS (E.G., CLOTHING OR EQUIPMENT)

05

ESTABLISH ROUTINE CLEANING SCHEDULES FOR SHARED EQUIPMENT

06

TRAIN ATHLETES AND COACHES IN FIRST AID FOR WOUNDS AND RECOGNITION OF WOUNDS THAT ARE POTENTIALLY INFECTED.

07

ENCOURAGE ATHLETES TO REPORT SKIN LESIONS TO COACHES AND ENCOURAGE COACHES TO ASSESS ATHLETES REGULARLY FOR SKIN LESIONS



West Virginia Secondary School Activities Commission



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Heat Acclimatization / Heat Illness and Air Quality

July 2026

Members,

As we enter the Fall preseason and with extreme heat continuing to impact West Virginia, it is essential to remind all member schools that this period remains one of the highest-risk times of the year for heat-related illnesses and deaths. A strong commitment to advanced planning, preparation, and consistent communication is critical to ensuring that best-practice prevention and management strategies are fully implemented to reduce the risk of death and disability.

Over the next several months, repeated alerts are appropriate as temperatures may fluctuate significantly. When a heat wave is predicted, coaches and school administrators should be reminded through email, social media, and direct communication of the importance of modifying activities and practice schedules. It is also important to emphasize that heat illness is not limited to football. Any student participating in outdoor activities or exercising in hot environments is vulnerable, including those involved in marching band, cheer, cross-country, soccer, and even indoor activities held in non-air-conditioned gyms.

With the increased use of Wet Bulb Globe Temperature (WBGT) devices, state associations should continue educating member schools on updated policies and procedures related to heat acclimatization and heat illness prevention. The NFHS Foundation's educational video on WBGT remains a valuable resource: <https://nfhsfoundation.org/wet-bulb-globe/>

Air Quality also continues to pose challenges in many parts of the country. During periods of suspected or forecasted high air pollution, the Air Quality Index (AQI) should be checked prior to all practices and contests. Local AQI information can be found at: <https://www.airnow.gov>

NFHS & NFHS SMAC Resources:

School administrators, athletic directors, coaches, parents, and students should also be made aware of the following resources from the NFHS and the NFHS Sports Medicine Advisory Committee (SMAC):

NFHS “Heat Acclimatization and Heat Illness Prevention Position Statement”

<https://a-us.storyblok.com/f/1022696/x/42da7079ed/heat-acclimatization-and-heat-illness-prevention-position-statement-final-10-6-25.pdf>

NFHS “Position Statement and Recommendations for Maintaining Hydration to Optimize Performance and Minimize the Risk for Exertional Heat Illness”

<https://a-us.storyblok.com/f/1022696/x/fd2b8d7658/nfhs-hydration-position-statement-final-10-6-25.pdf>

NFHS “Position Statement on Physical Activity, Air Quality and Wildfires

<https://www.nfhs.org/media/7212236/nfhs-position-statement-on-air-quality-april-2023-final.pdf>

NFHS “Emergency Action Plan (EAP) for Interscholastic Activities Position Statement”

<https://assets.nfhs.org/umbraco/media/7213372/nfhs-smac-emergency-action-plans-eap-position-statement-final-10-7-24.pdf>

NFHS “Heat Illness Prevention” Online Course from NFHSLearn.com

<https://nfhslearn.com/courses/heat-illness-prevention-2>

NFHS “The Collapsed Student” Online Course from NFHSLearn.com

<https://nfhslearn.com/courses/the-collapsed-athlete>

NFHS “Sudden Cardiac Arrest” Online Course from NFHSLearn.com

<https://nfhslearn.com/courses/sudden-cardiac-arrest>

NFHS “Emergency Action Planning for Afterschool Programs” Online Course from NFHSLearn.com

<https://nfhslearn.com/courses/emergency-action-planning-for-afterschool-programs>

NFHS “CPR and AED Training” Online Course from NFHSLearn.com

<https://nfhslearn.com/courses/cpr-aed>

Other resources are available on the following link to the NFHS Sports Medicine web page: <https://nfhs.org/resources/sports-medicine>

Critical Reminders:

It is crucial that heat-acclimatization guidelines are strictly followed, with extra vigilance during the first 3–4 days of any transition or acclimatization period. This is when students are most vulnerable to heat illness.

Although prevention is our goal, personnel must be prepared to rapidly identify, assess, and appropriately treat exertional heat stroke. Remember: cool first and transport second.

Alex Diamond, DO, MPH, FAAP, FAMSSM

Chair – NFHS Sports Medicine Advisory Committee (SMAC)



Heat Acclimatization and Heat Illness Prevention Position Statement

National Federation of State High School Associations (NFHS) Sports Medicine Advisory Committee (SMAC)

Exertional Heatstroke (EHS) is the leading cause of preventable death in high school athletics. Students participating in high-intensity, long-duration or repeated same-day sports practices and training activities during the summer months or other hot-weather days are at greatest risk.

This NFHS Sports Medicine Advisory Committee (SMAC) position statement is the companion piece to the NFHSLearn.com online course “Heat Illness Prevention.” **This position statement provides an outline of “Fundamentals” and should be used as a guiding document by member state associations.** Further and more detailed information can be found within the NFHSLearn.com online course and the resources listed below and the NFHS SMAC *“Position Statement and Recommendations for Maintaining Hydration to Optimize Performance and Minimize the Risk for Exertional Heat Illness” (October 2025):*

Following the recommended guidelines in this position statement and “Heat Illness Prevention” can reduce the risk and incidence of EHS and the resulting deaths and injuries in high school athletics. The NFHS recognizes that various states and regions of the country have unique climates and variable resources, and that there is no “one-size-fits-all” optimal acclimatization plan. However, the NFHS and the NFHS SMAC strongly encourage member state associations to incorporate all of the “Fundamentals” into any heat acclimatization plan to improve athlete safety. In addition, the online course **“Heat Illness Prevention” should be made available for all coaches.** (<https://nfhslearn.com/courses/heat-illness-prevention-2>)

Heat Acclimatization and Safety Priorities:

Recognize that EHS is the leading preventable cause of death among high school athletes.

Know the importance of a formal pre-season heat acclimatization plan.

Know the importance of having and implementing a specific hydration plan, keeping your athletes wellhydrated, and encouraging and providing ample opportunities for regular fluid replacement.

Know the importance of appropriately modifying activities in relation to the environmental heat stress and contributing individual risk factors (e.g., illness, obesity) to keep your athletes safe and performing well.

Know the importance for all members of the coaching staff to closely monitor all athletes during practice and training in the heat and recognize the signs and symptoms of developing heat illnesses.

Know the importance of and resources for establishing an emergency action plan and promptly implementing it in case of suspected EHS or other medical emergency.

Energy drinks are NOT appropriate hydration fluids. Refer to NFHS SMAC *“Position Statement and Recommendations for the Use of Energy Drinks by Young Athletes” (October 2024):*

Fundamentals of a Heat Acclimatization Program:

1. Physical exertion and training activities should begin slowly and continue progressively. An athlete cannot be “conditioned” in a period of only two to three weeks.

- Begin with shorter, less intense practices and training activities, with longer recovery intervals between bouts of activity.
- Minimize protective gear (such as helmets and pads) during first several practices and introduce additional uniform and protective gear progressively over successive days.
- Emphasize instruction over conditioning during the first several practices.

Rationale: The majority of heat-related deaths happen during the first few days of practice, usually prompted by doing too much, too soon, and in some cases with too much protective gear on too early in the season (wearing helmet, shoulder pads, pants and other protective gear). Players must be allowed the time to adapt safely to the environment, intensity, duration, and uniform/equipment.

2. Keep each athlete’s individual level of conditioning and medical status in mind and adjust activity accordingly. These factors directly affect exertional heat illness risk.

Rationale: Athletes begin each season’s practices and training activities at varying levels of physical fitness and varying levels of risk for exertional heat illness. For example, there is an increased risk if the athlete is obese, unfit, has been recently ill, has a previous history of exertional heat illness, or has Sick Cell Trait.

Among American sports, **football has the highest incidence of exertional heat stroke** (EHS) despite decades of prevention strategies. Based on recent reports, 100% of high school and college EHS football fatalities occurred during conditioning sessions. Lineman are at the at-risk population, constituting 97% of football EHS deaths. Lineman heat up faster and cool down slower than other players. Football EHS is tied to:

- High-intensity drills and conditioning that is not specific to individual player positions.
- Physical exertion as punishment.
- Failure to modify physical activity for high heat and humidity.
- Failure to recognize early signs and symptoms of EHS.
- Death when cooling is delayed.

To prevent football EHS, the following recommendations are made:

- All training and conditioning should be position-specific.
- Physical activity should be modified per the heat load.
- Understand that some players have a “do or die” mentality that supersedes their personal safety.
- Never use physical exertion as punishment.
- Eliminate conditioning tests, serial splints, and any reckless drills that are inappropriate for lineman.
- Consider air-conditioned venues for linemen during hot practices.
- To prevent EHS, train lineman based on game demands.

3. Adjust intensity (lower) and rest breaks (increase frequency/duration), and consider reducing uniform and protective equipment, while being sure to monitor all players more closely as conditions are increasingly warm/humid, especially if there is a change in weather from the previous few days.

Rationale: Coaches must be prepared to immediately adjust for changing weather conditions, while recognizing that tolerance to physical activity decreases and exertional heat illness risk increases, as the heat and/or humidity rise. Accordingly, it is imperative to adjust practices and/or competitions to maintain safety and performance. Coaches can monitor the athletes' weights pre and post practice to ensure adequate fluid replacement, and can follow guidelines for hot and humid weather including using Wet Bulb Globe Temperature (WBGT) readings.

4. *Athletes must begin practices and training activities adequately hydrated.*

Rationale: While proper hydration alone will not necessarily prevent exertional heat illness, it will decrease risk. Athletes can observe the color of their urine, which should be straw yellow or the color of lemonade, when adequately hydrated.

A Urine Color Chart link: <https://www.healthdirect.gov.au/urine-colour-chart>

5. *Recognize early signs of distress and developing exertional heat illness, and promptly adjust activity and treat appropriately. First aid should not be delayed!*

Rationale: An athlete will often show early signs and/or symptoms of developing exertional heat illness. If these signs and symptoms are promptly recognized and the athlete is appropriately treated, serious injury can be averted and the athlete can often be treated, rested and returned to activity when the signs and symptoms have resolved.

6. *Recognize more serious signs of exertional heat illness (clumsiness, stumbling, collapse, obvious behavioral changes and/or other central nervous system problems), immediately stop activity and promptly seek medical attention by activating the Emergency Medical System (or Call 9-1-1). On-site rapid cooling should begin immediately.*

Rationale: Immediate medical treatment and prompt rapid cooling can prevent death or minimize further injury in the athlete with EHS. Ideally, tubs, pools, tarps (TACO Method) or tubs of ice water to be used for rapid cooling of athletes and should be available on-site and personnel should be trained and practiced in using these facilities for rapid cooling. **Remember: Cool first, transport later.**

7. *An Emergency Action Plan (EAP) with clearly defined written and practiced protocols should be developed and in place ahead of time.*

Rationale: An EAP should be in place in case of any emergency, as a prompt and appropriate response in any emergency situation can save a life. The EAP should be designed and practiced, addressing all teams (freshman, junior varsity, and varsity) and all practice and game sites. For heat illness emergencies, emphasis must be placed on **full body cooling prior to transport.**

References:

American Academy of Pediatrics. Policy Statement—Climatic Heat Stress and Exercising Children and Adolescents. *Pediatrics*. 2011;128(3):e741-7.

Casa, D. J, et al. (2015). National Athletic Trainers' Association Position Statement: Exertional Heat Illnesses. *Journal of Athletic Training*, 50(9), 986–1000

Casa, D. J., Csillan, D. (2009). Preseason Heat-Acclimatization Guidelines for Secondary School Athletics. *Journal of Athletic Training*, 44(3), 332–333

Anderson, Scott A., et al. Preventing Exertional Heat Stroke in Football: Time for a Paradigm Shift. *Sports Health*, 2024 Jun 14;17(3): 484-490.

October 2025

April 2022

April 2018

April 2015

April 2012

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Acclimatization:

For Football:

Days 1-2: Organize Practice, Helmets Only, No Contact

Days 3-4: Helmet and Shoulder Pads, Soft Equipment Contact Only (bag, shield, sled, tackling wheel, etc.)

Day 5: Full Pads - Soft Equipment Contact Only (bag, shield, sled, tackling wheel, etc.)

Day 6: Full Pads, Full Contact

Hydration:

Water breaks are to be provided as outlined in the activity modification chart.

Treatment:

Monitoring of student athlete safety will be continuous during any physical activity. School staff should be educated on the signs and symptoms of external heat illness. The signs and symptoms include, but are not limited to:

- Headache, confusion or “out of it” look, disorientation, or dizziness, altered consciousness or coma, nausea or vomiting, diarrhea, hot and moist or dry skin. A rectal temperature greater than 104 F at time of incident indicates exertional heat stroke.
- **If a student athlete is suspected of having exertional heat stroke, the athlete MUST be cooled first, immediately followed by calling the EMS.**

A cooling zone must be designated at each practice site. Treatment must include minimum:

- Removing excess clothing
- Placing patients in a cold-water immersion tub (35-39 F), or ice floating on top of tub if no thermometer is available to check the water temp.
- Placing an ice-cold towel over the head/neck and rewetting/replacing every 2 minutes while in the

Once diagnosed with exertional heat illness, the student athlete must complete a rest period and/or obtain medical clearance from a physician before returning to play, depending on the type of illness diagnosed.

While the majority of this Heat Acclimatization and Heat Illness Policy and Procedures addresses the risks of practicing in extreme heat conditions, all physical activities carry risk in the heat which clearly includes competitions. It is recommended that all steps be taken to mitigate risk such as, but not limited to, moving start times, increasing frequency and duration of breaks, increasing water breaks, increasing available shade and having fans available, etc.

This policy should be reviewed annually with all appropriate school personnel.

Note – This policy was developed using information provided by the Korey Stringer Institute.

Approved by the WVSSAC Board of Directors on May 17, 2022, on recommendation of the WVSSAC Sports Medicine Committee.

Revised Spring 2024

BEAT THE HEAT

Summer's high temperatures put student athletes at increased risk of heat illness. There are several types of heat illness. They range in severity, from heat cramps and heat exhaustion, which are common but not severe, to heat stroke, which can be deadly. Although exertional heat stroke can be fatal, death is preventable if it's quickly recognized and properly treated.

DEHYDRATION AND HEAT ILLNESSES



It takes only **30 minutes** for cell damage to occur with a core body temperature of 105 degrees or higher.

Fluid replacement should be based on **SWEAT LOSS**.



As of August 2022, 14 states mandate all best practice heat acclimatization standards at the high school level.



Exertional heat stroke is one of the top three killers of athletes and soldiers in training.

- From 2015-19, 17 athletic heat stroke fatalities were reported.
- It takes seven to 14 days for a body to adapt to exercising in the heat.
- Dehydration at levels of 3% to 4% body mass loss can reduce muscle strength by an estimated 2%.

SAFETY TIPS



Have sports drinks on hand for workout sessions lasting longer than an hour.

Keep beverages cold – cold beverages are consumed 50% more than warm beverages.

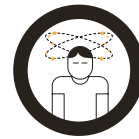
Hydrate before, during and after activity.

Remove unnecessary equipment, such as helmets and padding, when environmental conditions become extreme.



Clothing worn by athletes should be light colored, lightweight and protect against the sun.

Signs of exertional HEAT ILLNESS



Headache, lightheadedness, dizziness, confusion and disorientation

Excessive sweating and/or flushing

Fatigue

Nausea and/or vomiting

Chills and/or goose bumps

Cramps, muscular tightening and spasms



Core body temperature of more than 105 degrees



Signs of nervous system dysfunction, such as confusion, aggression and loss of consciousness



Increased heart rate

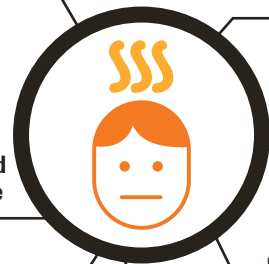
Rapid breathing



Low blood pressure

Seizures

Excessive sweating



- During the first week, practices shouldn't exceed 120 minutes and should be limited to one practice per day.
- Also, during the first week, slowly integrate equipment into practice using the following schedule:
 - Days 1-2: Helmet/headgear only
 - Days 3-5: Helmet and shoulder pads
 - Day 6: Begin full equipment
- Follow a work-to-rest ratio based on environmental conditions.
- Get a location-specific measurement of heat stress using a wet-bulb globe temperature, which accounts for ambient temperature, relative humidity, wind and radiation from the sun.

- If someone is suffering from exertional heat stroke, remember to cool first and transport second.
- Have shade and cooling stations available and large cold tubs ready before all practices and games in case cold water immersion is needed to treat exertional heat stroke.
- According to best practice, the optimal way to determine core temperature, and whether someone is experiencing exertional heat stroke, is through the use of a rectal thermometer, which should be done by a trained medical professional, such as an athletic trainer.

WVSSAC

SUDDEN CARDIAC ARREST AWARENESS

All coaches are required to complete the NFHS Sudden Cardiac Awareness course annually.

What is Sudden Cardiac Arrest?

- Occurs suddenly and without warning.
- An electrical malfunction (short-circuit) causes the bottom chambers of the heart (ventricles) to beat dangerously fast (ventricle tachycardia or fibrillation) and disrupts the pumping ability of the heart.
- The heart cannot pump blood to the brain, lungs and other organs of the body.
- The person loses consciousness (passes out) and has no pulse.
- Death occurs within minutes if not treated immediately.

What are the symptoms/warning signs of Sudden Cardiac Arrest?

- SCA should be suspected in any athlete who has collapsed and is unresponsive.
- Fainting, a seizure, or convulsions during physical activity.
- Dizziness or lightheadedness during physical activity.
- Unusual fatigue/weakness.
- Chest pain.
- Shortness of breath
- Nausea/vomiting.
- Palpitations (heart is beating unusually fast or skipping beats).
- Family history of sudden cardiac arrest under 50.

ANY of these symptoms/warning signs may necessitate further evaluation from your physician before returning to practice or a game.

What causes Sudden Cardiac Arrest?

- Conditions present at birth (inherited and non-inherited heart abnormalities).
- A blow to the chest (Commotio Cordis)
- An infection/inflammation of the heart, usually caused by a virus. (Myocarditis).
- Recreational/Performance Enhancing drug use.
- Other cardiac & medical conditions / Unknown causes. (Obesity/idiopathic).

What are ways to screen for Sudden Cardiac Arrest?

- The American Heart Association recommends a pre-participation history and physical which is mandatory annually in West Virginia.
- Always answer the heart history questions on the student Health History section of the WVSSAC Physical Form completely and honestly.
- Additional screening may be necessary at the recommendation of a physician.

What is the treatment for Sudden Cardiac Arrest?

- Act immediately: time is critical to increase survival rate.
- Activate emergency action plan.
- Cal 911.
- Begin CPR.
- Use Automated External Defibrillator (AED).

Where can one find additional information?

- Contact your primary health care provider.
- American Heart Association (www.heart.org)

TEN LEGAL DUTIES FOR **COACHES**

- 1. PROPERLY PLAN THE ACTIVITY**
- 2. PROVIDE PROPER INSTRUCTION**
- 3. WARN OF INHERENT RISKS**
- 4. PROVIDE A SAFE PHYSICAL ENVIRONMENT**
- 5. PROVIDE ADEQUATE AND PROPER EQUIPMENT**
- 6. MATCH YOUR ATHLETES APPROPRIATELY**
- 7. EVALUATE ATHLETES FOR INJURY OR INCAPACITY APPROPRIATELY**
- 8. SUPERVISE THE ACTIVITY CLOSELY**
- 9. PROVIDE APPROPRIATE EMERGENCY ASSISTANCE**
- 10. PROTECT AGAINST PHYSICAL AND PSYCHOLOGICAL HARM FROM OTHERS**



TOBACCO POLICY ANNOUNCEMENT

School administration and the WVSSAC would like to remind all individuals of the WV State board Policy 4373, that prohibits the use of ANY tobacco products on school property and during school related events. Not only is tobacco use and distribution illegal on school property, but tobacco is directly linked to numerous health problems. Please do your part to help reduce tobacco use.

DON'T LET AN INJURY LEAD TO AN OPIOID ADDICTION

2 MILLION athletes are expected to suffer a sports injury this year
Many of these athletes will be prescribed OPIOID PAIN KILLERS
75% of High School HEROIN users started with prescription drugs

HIGH SCHOOL ATHLETES ARE AT RISK OF BECOMING ADDICTED TO PRESCRIPTION DRUGS

- 28.4% used medical opioids at least once over a three year period.
- 11% of high school athletes have used an opioid medication for non medical reasons.
- Nearly 25% of students who chronically use prescription opioids also use heroin.

WHAT ARE OPIOIDS??

Opioids are a powerful and addictive type of prescription painkiller that have similar chemical properties and addiction risks as heroin. While opioids may provide temporary relief, they do nothing to address the underlying injury and can have serious side effects

**These drugs may lead to:
dependence, tolerance, accidental
overdose, coma and death**

The most common prescribed opioid painkillers in West Virginia are:

- Oxycodone (OxyContin)
- Hydrocodone (Lortab and Vicodin)

HOW TO PROTECT YOUR CHILD

- Talk to your healthcare provider about alternative pain management treatment options.
 - First-time prescription opioids users have a 64% higher risk of an early death, than patients who use alternative pain medication.
- If your child is prescribed an opioid painkiller, talk about the dangers of misusing medication, including overuse and medication sharing.
- Monitor your child's intake of prescription medication to ensure he/she is following dosage instructions.
- Safely dispose of any unused medication through a prescription drug drop box or a DEA Take-Back program.

NON - NARCOTIC PAIN MANAGEMENT ALTERNATIVES

Physical Therapy
Chiropractic
Massage Therapy
Acupuncture
Over-the-Counter Medication



Emergency Action Plan

§127-2-15. Emergency Action Plan (EAP).

15.1. Effective: *December 31, 2017*, each member school shall adopt and submit to the WVSSAC and to the county board of education an EAP for athletics, designed to respond to athletic injuries that occur on school property during school-sponsored athletic practices and events.

15.2. Each EAP shall include:

15.2.a. Implementation of the EAP for every sport at every level and venue. The EAP shall discuss how it is to be implemented with the participation of the school's principal and athletic director (if any), coaches, and athletes.

15.2.b. Training. The EAP shall include any necessary training for any person designated as responsible for any portion of the implementation of the EAP. Training may be in person or online, as may be available to the school.

15.2.c. Protocol for summoning emergency medical assistance. The EAP shall discuss how the school's sports teams will assign responsibility for summoning emergency medical assistance in the case of an emergency during a practice or event.

15.2.d. Protocol for beginning Cardiopulmonary Resuscitation (CPR). The EAP shall discuss how the school's sports teams will assign responsibility for beginning CPR in the event it is necessary. Each sports team must have individuals trained in CPR. The school shall provide proper training for any individual assigned responsibility for performing CPR.

15.2.e. Protocol for the use of Automated External Defibrillator (AED). Each member school will have an accessible AED on the school or event grounds during the duration of all athletic events and practices. The EAP must address how the school's sports teams will assign responsibility for retrieving and using an AED in the event it is necessary. Each sports team must be instructed on the location of the nearest AED to any practice or event facility. The school shall provide proper training to any individual assigned responsibility for using an AED. (2021-22)

15.2.f. Protocol for the treatment of heat stroke. The EAP must address how the school's sports teams will prepare for and treat heat stroke. Each sports team that practices outdoors is recommended to have an emersion tub available, and must have water, ice, and towels, to be used for the treatment of heat stroke. The EAP must address how the

school's sports teams will assign responsibility for obtaining these items and preparing them before practice or game begins.

15.2.g. Written records. The EAP shall require that each of the school's sports teams assign responsibility for the items discussed above at the beginning of each season, and record those assignments on a written record, which record shall be retained by the sports team and the school.

15.2.h. Symptoms and risk factors for sudden cardiac arrest. The EAP requires that schools train athletes, coaches, and volunteers about the symptoms and risk factors for sudden cardiac arrest.

15.2.i. Coordination with local Emergency Medical Systems. The EAP shall require that schools coordinate with their local Emergency Medical Services (EMS) personnel, notify EMS personnel of the availability of AEDs at the school, and notify EMS personnel of the EAP adopted by the school.

15.2.j. Follow up retraining. The EAP shall require that school sports teams that respond to an emergency incident meet to discuss their response after the incident has passed. Discussion shall center on the team's response to the incident, areas for improvement, and retraining that may be necessary, and any counseling that may be required for the individuals involved.



GUIDELINES ON HANDLING PRACTICES AND CONTESTS DURING LIGHTNING OR THUNDER DISTURBANCES

National Federation of State High School Associations (NFHS) Sports Medicine Advisory Committee (SMAC)

It is important that state associations continue to educate their member schools on the importance of having an established Lightning Policy / Plan in place for all outdoor high school sports and activities and for indoor swimming pools and that this Policy / Plan is current, practiced and executed.

These guidelines provide a default policy to those responsible or sharing duties for making decisions concerning the suspension and restarting of practices and contests based on the presence of lightning or thunder. The preferred sources from which to request such a policy for your facility would include your state association and the nearest office of the National Weather Service.

PROACTIVE PLANNING

1. Assign a specific staff member to monitor local weather conditions before and during practices and contests. This staff member is charged with suspending outdoor activities and determining when to resume activities. Any individual following these guidelines shall not be challenged.
2. Develop an emergency action plan, including identification of appropriate nearby safer areas and determine the amount of time needed to get everyone to a designated safer area:
 - a. A designated safer place is a substantial building with plumbing and wiring where people live or work, such as a school, gymnasium or library. An alternate safer place from the threat of lightning is a fully enclosed (not convertible or soft top) metal car or school bus.
3. Develop criteria for suspension and resumption of play:
 - a. When thunder is heard or lightning is seen*, the leading edge of the thunderstorm is close enough to strike your location with lightning. Suspend play for at least 30 minutes and vacate the outdoor activity to the previously designated safer location immediately.
 - b. 30-minute rule. Once play has been suspended, wait at least 30 minutes after the last thunder is heard or lightning is witnessed* prior to going outdoors and resuming play.
 - c. Any subsequent thunder or lightning* after the beginning of the 30-minute count will reset the clock and another 30-minute count will begin.
 - d. If available, data from a nationally connected network for lightning detection network should be monitored closely when storms are possible or during lightning delays. Play shall be suspended when lightning is within a 10-mile radius of the event and will not be resumed until at least 30 minutes have passed since the last lightning within the 10-mile radius. However, never depend on the reliability of any detection device if the sky looks threatening, you hear thunder, or see lightning*. Visual and audio indications of a storm should always take precedence over information from a mobile app or lightning-detection device.

* – At night, under certain atmospheric conditions, lightning flashes may be seen from distant storms. In these cases, it may be safe to continue an event. If no thunder can be heard and the flashes are low on the horizon, the storm may not pose a threat. Independently verified lightning detection information would help eliminate any uncertainty.

4. Review the lightning safety policy annually with all administrators, coaches and game personnel and train all personnel.
5. Inform student-athletes and their parents of the lightning policy at start of the season.

October 2024

January 2021

March 2018

October 2014

January 2014

October 2010

October 2007

January 2004

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WEST VIRGINIA SECONDARY SCHOOL ACTIVITIES COMMISSION

Revised 3-26

2875 Staunton Turnpike - Parkersburg, WV 26104

ATHLETIC PARTICIPATION/PARENTAL CONSENT/PHYSICIAN'S CERTIFICATE FORM

(Form required each school year on or after May 1". File in School Administration Office)

ATHLETIC PARTICIPATION/ PARENTAL CONSENT**PART I**

Name _____ School Year: _____ Grade Entering: _____

Home Address: _____ Home Address of Parents: _____

City: _____ City: _____

Phone: _____ Date of Birth: _____ Place of Birth: _____

Last semester I attended _____ (High School) or (Middle School). We have read the condensed eligibility rules of the WVSSAC athletics. If accepted as a team member, we agree to make every effort to keep up schoolwork and abide by the rules and regulations of the school authorities and the WVSSAC.

PART II - PARENTAL CONSENT**INDIVIDUAL ELIGIBILITY RULES**

- Attention Athlete! To be eligible to represent your school in any interscholastic contest, you:
- Must be a regular bona fide student in good standing of the school. (See exception under Rule 127-2-3) must qualify under the Residence and Transfer Rule (127-2-7)
- Must have earned at least 2 units of credit the previous semester. Summer School may be included. (127-2-6)
- Must have attained an overall "C" (2.00) average the previous semester. Summer School may be included. (127-2-6) must not have reached your 15th (MS), 19th (HS) birthday before July 1 of the current school year. (127-2-4)
- Must be residing with parent(s) as specified by Rule 127-2-7 and 8.
unless parents have made a bona fide change of residence during school term. Unless an AFS or other Foreign-Exchange student (one year of eligibility only).
- Unless the residence requirement was met by the 365 calendar days attendance prior to participation. if living with legal guardian/custodian, may not participate at the varsity level. (127-2-8)
- Must be an amateur as defined by Rule 127-2-11.
- Must have submitted to your principal before becoming a member of any school athletic team Participation/Parent Consent/Physician Form, completely filled in and properly signed, attesting that you have been examined and found to be physically fit for athletic competition and that your parents' consent to your participation. (127-3-3)
- Must not have transferred from one school to another for athletic purposes. (127-2-7)
- Must not have received, in recognition of your ability as a HS or MS athlete, any award not presented or approved by your school or the WVSSAC. (127-3-5)
- Must not, while a member of a school team in any sport, become a member of any other organized team or as an individual participant in an unsanctioned meet or tournament in the same sport during the school sport season (See exception 127-2-10).
- Must follow All Star Participation Rule. (127-3-4)
- Must not have been enrolled in more than (14) semesters in grades 6 to 12.
- Eligibility to participate in interscholastic athletics is a privilege you earn by meeting not only the above listed minimum standards but also all other standards set by your school and the WVSSAC. If you have any questions regarding your eligibility or are in doubt about the effect any activity or action might have on your eligibility, check with your principal or athletic director. They are aware of the interpretation and intent of each rule. Meeting the intent and spirit of 'WVSSAC' standards will prevent athletes, teams, and schools from being penalized.

MEDICAL DISQUALIFICATION OF THE STUDENT-ATHLETE/ WITHHOLDING A STUDENT-ATHLETE FROM ACTIVITY

The member school's team physician has the final responsibility to determine when a student-athlete is removed or withheld from participation due to an injury, an illness or pregnancy. In addition, clearance for that individual to return to activity is solely the responsibility of the member school's team physician or that physician's designated representative.

I understand that participation may include, when necessary, early dismissal from classes and travel to participate in interscholastic athletic contests. I will not hold the school authorities or West Virginia Secondary School Activities Commission responsible in case of accident or injury as a result of this participation. I also understand that participation in any of those sports listed above may cause permanent disability or death. Please check appropriate space: **He/She has student accident insurance available through the school () ; has football insurance coverage available through the school () ; is insured to our satisfaction () .**

I also give my consent and approval for the above named student to receive a physical examination, as required in Part IV, Physician's Certificate, of this form, by an approved health care provider as recommended by the named student's school administration.

I consent to WVSSAC's use of the herein named student's name, likeness, and athletically related information in reports of Inter-School Practices or Scrimmages and Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

I have read/reviewed the concussion and Sudden Cardiac Arrest information as available through the school and at WVSSAC.org. (Click Sports Medicine)

Date: _____ Student Signature _____ Parent Signature _____

PART III - STUDENT'S MEDICAL HISTORY
(To be completed by parent or guardian prior to examination)

Name _____ Birthdate ____ / ____ / ____ Grade ____ Age ____

Has the student ever had:

Yes No 1. Chronic or recurrent illness? (Diabetes, Asthma, Seizures, etc.)

Yes No 2. Any hospitalizations?

Yes No 3. Any surgery (except tonsils)?

Yes No 4. Any injuries that prohibited your participation in sports?

Yes No 5. Dizziness or frequent headaches?

Yes No 6. Knee, ankle or neck injuries?

Yes No 7. Broken bone or dislocation?

Yes No 8. Heat exhaustion/sun stroke?

Yes No 9. Fainting or passing out?

Yes No 10. Have any allergies?

Yes No 11. Concussion? If Yes _____
Date _____

Yes No 12. Have any problems with heart/blood pressure?

Yes No 13. Has anyone in your family ever fainted during exercise?

Yes No 14. Take any medicine?

List:

Yes No 15. Wear glasses __, contact lenses __, dental appliances __?

Yes No 16. Have any organs missing (eye, kidney, testicle, etc.)?

Yes No 17. Has it been longer than 10 years since your last tetanus shot?

Yes No 18. Have you ever been told not to participate in any sport?

Yes No 19. Do you know of any reason this student should not participate in sports?

Yes No 20. Have a sudden death history in your family?

Yes No 21. Have a family history of heart attack before age 50?

Yes No 22. Develop coughing, wheezing, or unusual shortness of breath when you exercise?

Yes No 23. (Females Only) Do you have any problems with your menstrual periods.

PLEASE EXPLAIN ANY "YES" ANSWERS OR ANY OTHER ADDITIONAL CONCERNS.

I also give my consent for the physician in attendance and the appropriate medical staff to give treatment at any athletic event for any injury.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE ____/____/____

PART IV-VITAL SIGNS

Height _____ Weight _____ Pulse _____ Blood Pressure _____
Visual acuity: Uncorrected ____/____; Corrected ____/____ Pupils equal diameter: Y N

PART V - SCREENING PHYSICAL EXAM

This exam is not meant to replace a full physical examination done by your private physician.

Mouth:

Appliances Y N

Missing/loose teeth Y N

Caries needing treatment Y N

Enlarged lymph nodes Y N

Skin - infectious lesions Y N

Peripheral pulses equal Y N

Respiratory:

Symmetrical breath sounds Y N

Wheezes Y N

Cardiovascular:

Murmur Y N

Irregularities Y N

Murmur with Valsalva Y N

Abdomen:

Masses Y N

Organomegaly Y N

Any "YES" under Cardiovascular requires a referral to family doctor or other appropriate healthcare provider.

Musculoskeletal: (note any abnormalities)

Neck: Y N

Elbow: Y N

Knee/Hip: Y N

Hamstrings: Y N

Shoulder: Y N

Wrist: Y N

Ankle: Y N

Scoliosis: Y N

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response)

	Not at all	Several Days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge.	0	1	2	3
Not being able to stop or control worrying.	0	1	2	3
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

RECOMMENDATIONS BASED ON ABOVE EVALUATION:

After my evaluation, I give my:

____ Full Approval;

____ Full approval; but needs further evaluation by Family Dentist __ ; Eye Doctor __ ; Family Physician __ ; Other __ ;

____ Limited approval with the following restrictions: _____,

____ Denial of approval for the following reasons: _____