Ridgefield Little League

Ridgefield, CT

2023

**Safety Manual**

***For***

***Managers and Coaches***

***Play Hard - Play Safe***

***Ridgefield National LL (#2070107)***

***Ridgefield, CT 06877***

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# Introduction

This safety manual has been prepared to assist managers and coaches of little league age children to care for potential common injuries you might encounter. Also included are reference materials for more unusual circumstances (i.e. how to deal with lightning in the area). Certain topics included in this manual will be covered in the mandatory safety lecture scheduled a few weeks prior to the start of the season. Please read carefully the section on accident reporting as this is critical to maintaining our safety profile. Other conditions which might occur in the area of the field (such as the concession stand and storage shed) are included as you might be called to help in an emergency in these areas.

***Prevention is the key to minimizing accidents, and reporting all accidents or near accidents is critical***. Report all hazardous conditions to the Director of Safety immediately on the appropriate form, or if it is a non-serious accident, informally. Do not play on a field that is not safe or with unsafe playing equipment. Be sure your players are fully equipped at all times, especially catchers and batters and check your team’s equipment often. Most importantly, use common sense when dealing with the injured child. Children are not “small adults” and have injuries unique to their growing bodies. The idea of “playing through pain” should not be advocated in this age population.

The risk of concussions has become of increasing concern in recent years. To provide managers, coaches and parents with the latest tools and information on concussion safety, you can now access the CDC HEADS UP microsite directly through the RLL website. All content is maintained by the CDC and will automatically keep the site current with the latest HEADS UP content.

Have a great season and if anyone has any questions or needs advice, feel free to contact me.

Anthony Labrusciano

RLL Safety Director

Cell: (732) 829-1992

Email: Safety@RidgefieldLittleLeague.org

***RLL President’s Safety Message – 2023***

**To All Ridgefield Little League Volunteers and Parents:**

Ridgefield Little League considers a safe environment for the children in our programs to be of paramount importance.  This means being adequately prepared for any emergency situation whether it involves a player, a coach, a parent, or spectator.  This manual will guide you through most of the things that can happen during the course of our season and in our operations.  **Please read through it carefully. Coaches should keep a copy with them at all times.**

This safety manual has been updated by our Safety Director, Anthony Labrusciano. An annual review is required by Little League International (LLI).  No other youth baseball organization requires its leagues to do this.

One important change intended to help improve safety are the bat regulations. Beginning with the 2018 season, non-wood and laminated bats used in the Little League (Majors) and below, Intermediate (50-70) Division, and Junior League divisions, as well as the Little League Challenger Division, shall bear the USA Baseball logo signifying that the bat meets the USABat – USA Baseball’s Youth Bat Performance Standard. All BPF – 1.15 bats will be prohibited beginning with the 2018 season. Additionally, starting in 2018, the bat diameter shall not exceed 2-5/8 inches for these divisions of play.

**Some Quick Reminders:**

All RLL volunteers must complete the **Little League Volunteer Application Form annually**, whereupon RLL will conduct a national background check.  Only those volunteers who pass this check will be allowed to work with children in our league.  RLL’s Safety Director, Anthony Labrusciano, will forward a secure online link provided by JDP Background Screening to all RLL volunteers so that they can complete their volunteer application prior to the start of the season. For this reason, when registering as a volunteer, personal information including your social security number is required. Ridgefield Little League does not maintain this information.

All managers and coaches in all divisions are also required to attend RLL’s annual First Aid Training & Safety Clinic.  Dr. Angelo Ciminiello will make a safety presentation which will include valuable information for all, including information on arm care that all AAA and Majors coaches will need to know in order to protect young arms. We will also spend time with a trainer from the Positive Coaching Alliance focusing on the important role coaches can have in influencing a player’s season and life.

All managers and coaches are also required to attend the RLL Coaches’ Clinics. This is an important resource for new and older coaches which covers the proper instruction of players; focusing on skill development, running an effective practice, and exercises.  Two coaches’ clinics will be provided this year: One clinic will be for the Tee Ball, Rookies and A divisions; the second clinic will be for the AA, AAA and Majors divisions.

Finally, all **AAA & Majors** managers and coaches MUST become certified in CPR & AED. If you fall into this group, consult your division director for the training schedule.  RLL invested in automated external defibrillators as an added measure of safety in the event of any emergency.  With this investment, RLL has required that the managers of all **AAA & Majors** teams must become CPR/AED certified in order to be prepared in the event of an emergency.  Training, through the American Heart Association, results in a two-year certification.  RLL subsidizes the cost of this training for our volunteers.

Thank you for becoming an RLL volunteer.  Best wishes for a fun, memorable and safe season!

Regards,

Jeffrey Audevard

President, RLL

Cell:  914-837-0721

Email:  President@RidgefieldLittleLeague.org

# Safety Code

## **Dedicated to Injury Prevention**

* Responsibility for Safety procedures should be that of an adult member of the Ridgefield Little League.
* Arrangements should be made in advance of all games and practices for emergency medical services.
* Managers, coaches and umpires should have training in first aid.
* First-aid kits are issued to each team manager and are located at each concession stand.
* No games or practices should be held when weather or field conditions are not good, particularly when lighting is inadequate.
* Play area should be inspected frequently for holes, damage, stones, glass and other foreign objects.
* All team equipment should be stored within the team dugout, or behind screens, and not within the area defined by the umpires as “in play.”
* Only players, managers, coaches, and umpires are permitted on the playing field or in the dugout during games and practice sessions.
* Responsibility for keeping bats and loose equipment off the field of play should be that of a player assigned for this purpose or the team’s manager and coaches.
* Procedure should be established for retrieving foul balls batted out of the playing area.
* During practice and games, all players should be alert and watch the batter on each pitch.
* During warm-up drills, players should be spaced so that no one is endangered by wild throws or missed catches.
* All pre-game warm ups should be performed within the confines of the playing field and not within areas that are frequented by, and thus endanger spectators (i.e., playing catch, pepper, swinging bats, etc.)
* Equipment should be inspected regularly for the condition of the equipment as well as for proper fit.
* Batters must wear Little League approved protective helmets with facemasks OR C-flaps during batting practice and games.
* Catchers must wear a catcher's helmet, mask, throat guard, long model chest protector, shin guards and protective cup with athletic supporters at all times (males) for all practices and games.
* Managers should encourage all male players to wear protective cups and supporters for practices and games.
* Except when a runner is returning to a base, head first slides are not permitted.
* During sliding practice, bases should not be strapped down or anchored.
* At no time should “horse play” be permitted on the playing field.
* Parents of players who wear glasses should be encouraged to provide “safety glasses.”
* Players must not wear watches, rings, pins or metallic items during games and practices.
* The Catcher must wear a catcher's helmet and mask with a throat guard in warming up pitchers. This applies between innings and in the bull-pen during a game and also during practices.
* On-deck batters are not permitted.
* Adults are not allowed to warm up pitchers.

**SAFETY FIRST!**

BE ALERT!

CHECK PLAYING FIELD FOR HAZARDS

PLAYERS MUST WEAR PROPER EQUIPMENT

ENSURE EQUIPMENT IS IN GOOD SHAPE

MAINTAIN CONTROL OF THE SITUATION

MAINTAIN DISCIPLINE

BE ORGANIZED

KNOW PLAYERS’ LIMITS AND DON’T EXCEED THEM

MAKE IT FUN!

# Please Help Us Prevent One of Our Most Common Injuries

Whenever you or a player are catching a pitched ball, or pitching batting practice you are at risk of a serious injury. You must use an L-Screen when pitching, and a catcher’s mask when catching. This is not an option, but a mandatory step you must take.

# Field and Equipment Preparation

Managers and Coaches should enlist a parent from each team to do a safety check at each game.

**Field Condition**

* Playing Field
* Bases
* Benches
* Fences
* Bleachers

**Equipment – Check for condition and/or fit**

* Helmets
* Bats
* Spike Check
* Catcher’s equipment:

- Chest Protector

- Helmet

- Mask

- Shin Guards

- Cup

**First Aid Box**

* Ice packs in Ziploc bags
* Cleansing packs
* Band-Aids/Dressings
* Bee Sting Ointment
* Rubber Gloves
* Incident Report

**Available Phone**

* Emergency numbers posted.

# Pre-Season Field Safety Checklist

|  |  |  |  |
| --- | --- | --- | --- |
|  | Repairs Needed? |  | Repairs Needed? |
| ***Field Condition*** | **Yes** | **No** | ***Catchers Equipment*** | **Yes** | **No** |
| Backstop repair |  |  | Shin guard OK |  |  |
| Home plate repair |  |  | Helmets OK |  |  |
| Bases Secure |  |  | Face masks OK |  |  |
| Bases repair |  |  | Throat protector OK |  |  |
| Pitchers mound |  |  | Catchers cup (boys) |  |  |
| Batters box level |  |  | Chest protector |  |  |
| Batters box marked |  |  | Catchers mitt (boys) |  |  |
| Grass surface (even) |  |  |  |  |  |
| Gopher holes |  |  |  |  |  |
| Infield fence repair |  |  |  |  |  |
| Outfield fence repair |  |  | ***Safety Equipment*** |  |  |
| Foul ball net repair |  |  | First-aid Kit each team |  |  |
| Foul lines marked |  |  | Medical Release forms |  |  |
| Sprinkler condition |  |  | Ice for injuries |  |  |
| Warning track |  |  | Blanket for shock |  |  |
| Coaches boxes level |  |  | RLL Safety Manual |  |  |
| Coaches box marked |  |  | Injury Report Forms |  |  |
| Clay/dirt needed |  |  |  |  |  |
|  |  |  |  |  |  |
| ***Dugouts*** | **Yes** | **No** | ***Players Equipment*** | **Yes** | **No** |
| Fencing needs repair |  |  | Batting helmets OK |  |  |
| Bench needs repair |  |  | Jewelry removed |  |  |
| Roof needs repair |  |  | Bats inspected |  |  |
| Bat racks |  |  | Shoes checked |  |  |
| Helmet racks |  |  | Uniforms checked |  |  |
| Trash cans |  |  | Athletic cups (boys) |  |  |
| Clean up needed |  |  |  |  |  |
|  |  |  |  |  |  |
| ***Spectator Areas*** | **Yes** | **No** | ***Concessions Stand*** | **Yes** | **No** |
| Bleachers need repair |  |  | Fire extinguisher present & charged |  |  |
| Hand rails need repair |  |  | All proper health, food handling & emergency choking posters up |  |  |
| No smoking |  |  | First Aid kit stocked |  |  |
| Parking area safe |  |  |  |  |  |
| Protective screens OK |  |  |  |  |  |
| Bleachers clean |  |  |  |  |  |

# ASAP - What is it?

In 1995, ASAP (A Safety Awareness Program) was introduced with the goal of re-emphasizing the position of Safety Officer “to create awareness, through education and information, of the opportunities to provide a safer environment for kids and all participants of Little League Baseball ''. This manual is offered as a tool to place some important information at manager’s and coach’s finger tips.

#### Some Important Do’s and Don’ts

**Do...**

* Reassure and aid children who are injured, frightened, or lost
* Provide, or assist in obtaining, medical attention for those who require it.
* Know your limitations. Ask if there if there are any medical personnel stands (physicians, EMT’s, nurses, etc.) to assist for more serious injuries
* Carry your first-aid kit to all games and practices
* Assist those who require medical attention - and when administering aid, remember to look for signs of injury **(**Blood, Black-and-blue, deformity of joint etc.).
* **LISTEN** to the injured describe what happened and what hurts if conscious. Before questioning, you may have to calm and soothe an excited child.
* **FEEL** gently and carefully the injured area for signs of swelling, or grating of broken bone.
* Have your players’ Medical Clearance Forms with you at all games and practices.
* Make arrangements to have a cellular phone available when your game or practice is at a facility that does not have any public phones. Be aware that cellular phone service is inconsistent at Ridgebury School, Fitzgerald and Serfilippi fields. A telephone is located in the concession stand at the Fitzgerald field.
* Talk to your team afterwards about the situation. Often players are upset and worried when another player is injured. They need to feel safe and understand why the injury occurred.

**Don’t...**

* Administer any medications
* Provide any food or beverages (other than water)
* Hesitate in giving aid when needed
* Be afraid to ask for help if you’re not sure of the proper procedures (i.e., CPR, etc.)
* Transport injured individuals except in extreme emergencies
* Leave an unattended child at a practice or game
* Hesitate to report any present or potential safety hazard to the Director of Safety immediately!

# Ridgefield Little League Phone Numbers

President: **Jeffrey Audevard**

Cell: 914-837-0721

Safety Officer: **Anthony Labrusciano**

Cell: 732-829-1992

**Ridgefield Police – Emergency 911**

Ridgefield Police - Non-emergency203**-**438-6531

**Ambulance 911**

**Ridgefield Fire Department-Emergency 911**

Ridgefield Fire Department 203-431-2724

# Health and Medical - Giving First-Aid

***What is First Aid?***

***First Aid*** means exactly what the term implies -- it is the ***first care*** given to a victim. It is usually performed by the ***first person*** on the scene and continued until professional medical help arrives, (9-1-1 paramedics). At no time should anyone administering First-Aid *go beyond* his or her capabilities. ***Know your limits!***

The average response time on ***9-1-1*** calls is 5-7 minutes. En-route

Paramedics are in constant communication with the local hospital at all times, preparing them for whatever emergency action might need to be taken. You cannot do this. Therefore, do not attempt to transport a victim to a hospital. Perform whatever First Aid you can and wait for the paramedics to arrive.

***9-1-1 EMERGENCY NUMBER***

The most important help that you can provide to a victim who is seriously injured is to call for professional medical help. Make the call quickly, preferably from a cell phone near the injured person. If this is not possible, send someone else to make the call from a nearby telephone. Be sure that you or another caller follows these four steps:

* First Dial **9-1-1**.
* Give the dispatcher the necessary information. Answer any questions that he or she might ask. Most dispatchers will ask:

- The exact location or address of the emergency. Include the name of the city or town, nearby intersections, landmarks, etc.

- The telephone number from which the call is being made.

- The caller’s name.

- What happened - for example, a baseball related injury, bicycle accident, fire, fall, etc.

- How many people are involved?

- The condition of the injured person - for example, unconsciousness, chest pains, or severe bleeding.

- What help (first aid) is being given.

* Do not hang up until the dispatcher hangs up. The EMS dispatcher may be able to tell you how to best care for the victim.
* Continue to care for the victim until professional help arrives.
* Appoint somebody to go to the street and look for the ***ambulance*** and ***fire engine*** and flag them down if necessary. This saves valuable time. Remember, every minute counts.

***When to Call***

If the injured person is unconscious, call ***9-1-1*** immediately. Sometimes a conscious victim will tell you not to call an ambulance, and you may not be sure what to do. Call ***9-1-1*** anyway and request paramedics if the victim:

* Is or becomes unconscious.
* Has trouble breathing or is breathing in a strange way.
* Has chest pain or pressure.
* Is bleeding severely.
* Has pressure or pain in the abdomen that does not go away.
* Is vomiting or passing blood.
* Have seizures, a severe headache, or slurred speech.
* Appears to have been poisoned.
* Have injuries to the head, neck or back.
* Have possible broken bones.

If you have any doubt at all, call 9-1-1- and requests paramedics.

# First Aid-Kits

First Aid Kits will be furnished to each team at the beginning of the season. The most important part of your first aid kit is ice. Icing an injury reduces pain and minimizes swelling. Although instant ice packs will be available, it is a good idea to bring a bag of ice or a reusable blue ice brick with you in a cooler. You can never have enough ice!

Remember that cellular service in the Ridgebury area is inconsistent and a telephone has been place in the concession stand at Fitzgerald field.

The First Aid Kit will become part of the Team’s equipment package and shall be taken to all practices, batting cage practices, games (whether season or post-season) and any RLL Little League event where children’s safety is at risk.

To ***replenish materials*** in the Team First Aid Kit, the Manager, designated coaches or the appointed Team Safety Officer must contact the RLL Safety Officer. (See contact information and address in phone # section of this Safety Manual)

***Additional First-Aid Kits*** will be available in the concession stand at Aldrich and Serfilippi fields.

Additional ice packs will be available at the concession stand and from Eric Fuller, Safety officer. Follow the same procedures as above.

# Good Samaritan Laws

There are laws to protect you when you help someone in an emergency situation. The ***“Good Samaritan Laws” give legal protection*** to people who provide emergency care to ill or injured persons. When citizens respond an emergency and act as a *reasonable* and *prudent* person would under the same conditions, Good Samaritan immunity generally prevails. This legal immunity protects you, as a rescuer, from being sued and found financially responsible for the victim’s injury. For example, a reasonable and prudent person would:

* Move a victim only if the victim’s life was endangered.
* Ask a conscious victim for permission before giving care.
* Check the victim for life-threatening emergencies before providing further care.
* Summon professional help to the scene by calling ***9-1-1***.
* Continue to provide care until more highly trained personnel arrive.
* *Good Samaritan laws were developed to encourage people to help others in emergency situations*. They require that the “Good Samaritan” use common sense and a reasonable level of skill, not to exceed the scope of the individual’s training in emergency situations. They assume each person would do his or her best to save a life or prevent further injury. People are rarely sued for helping in an emergency. However, the existence of Good Samaritan laws does not mean that someone cannot sue. In rare cases, courts have ruled that these laws do not apply in cases when an individual rescuer’s response was grossly or willfully negligent or reckless or when the rescuer abandoned the victim after initiating care.

***Permission to Give Care***

If the victim is conscious, you must have his/her permission before giving first aid. To get permission you *must* tell the victim who you are, how much training you have, and how you plan to help. Only then can a conscious victim give you permission to give care.

Do not give care to a conscious victim who refuses your offer to give care.

If the conscious victim is an infant or child, permission to give care should be obtained from a supervising adult when one is available. If the condition is serious, permission is implied if a supervising adult is not present. Permission is also implied if a victim is unconscious or unable to respond. This means that you can assume that, if the person could respond, he or she would agree to care.

# Accident Reporting Procedures

***What to Report***

An incident that causes any player, manager, coach, umpire, or volunteer to receive medical treatment and/or first aid must be reported to the Director of Safety. This includes even passive treatments such as the evaluation and diagnosis of the extent of the injury or periods of rest.

***When to Report***

All such incidents described above must be reported to the Director of Safety

*within 48 hours* of the incident.

The Safety Director for 2023 is **Anthony Labrusciano** and he can be reached at:

Cell: 732-829-1992

Email: Safety@RidgefieldLittleLeague.org

***How to Make the Report***

Reporting incidents can come in a variety of forms. Most typically, they are *telephone conversations*. At a minimum, the following information must be provided:

* The name and phone number of the individual involved
* The date, time, and location of the incident
* As detailed a description of the incident as possible
* The preliminary estimation of the extent of any injuries
* The name and phone number of the person reporting the incident.
* A copy of the injury tracking report has been included in this appendix of this manual.

***Director of Safety’s Responsibilities***

Within 48 hours of receiving the incident report, the Director of Safety will contact the injured party or the party’s parents and (1) verify the information received; (2) obtain any other information deemed necessary; (3) check on the status of the injured party; and (4) in the event that the injured party required other medical treatment (i.e., Emergency Room visit, doctor’s visit, etc.) will advise the parent or guardian of the Ridgefield Little League’s insurance coverage and the provisions for submitting any claims.

If the extent of the injuries is more than minor in nature, the Director of Safety shall periodically call the injured party to (1) check on the status of any injuries, and (2) to check if any other assistance is necessary in areas such as submission of insurance forms, etc. until such time as the incident is considered “closed” (i.e., no further claims are expected and/or the individual is participating in the league again).

# Pitching Safety Tips

* Warm-up to throw, Don’t Throw to Warm Up
* Pitch Offensively, Play Defensively
* Pitch with Quality, Not Quantity
* Let Your Manager Know if you Experience Discomfort

# Conditioning & Stretching

Conditioning is an intricate part of *accident prevention*. Extensive studies on the effect of conditioning, commonly known as *“warm-up,”* have demonstrated that:

* The *stretching* and *contracting* of muscles just before an athletic activity improves general control of movements, coordination and alertness.
* Such drills also help develop the *strength* and *stamina* needed by the average youngster to compete with minimum accident exposure.
* The purpose of stretching is to increase *flexibility* within the various muscle groups and prevent tearing from *overexertion*.
* Stretching should never be done forcefully, but rather in a gradual manner to encourage looseness and flexibility.

**STRETCHING SHOULD TAKE 15 TO 20 MINUTES
BEFORE EACH PRACTICE OR GAME**

***Hints on Stretching***

* Stretch necks, backs, arms, thighs, legs and calves.
* Don’t ask the child to stretch more than he or she is capable of.
* Hold the stretch for at least 10 seconds.
* Don’t allow bouncing while stretching. This tears down the muscle rather than stretching it.
* Have one of the players lead the stretching exercises.

***Hints on Calisthenics***

* Repetitions of at least 10.
* Have kids synchronize their movements.
* Vary upper body with lower body.
* Keep the pace up for a good cardio-vascular workout.

# Sample Routine

**WARM UP**

Jog Bases 2 minutes

Shuttle Run (side to side) 1.5 minutes

Backward Running 1.5 minutes

**STRETCHING**

Wrist Flexor Stretch 1.5 minutes

Wrist Extensor Stretch .5 minutes

Arm Hugs 1 minute

Clock Stretch 1 minute

Trunk Twists .5 minute

Calf Stretch 1 minute

Quadriceps Stretch 1 minute

Figure Four Hamstring Stretch 1 minute

Inner Thigh Stretch 1 minute

# Hydration

Good *nutrition* is important for children. Sometimes, the most important nutrient children need is *water* – especially when they’re physically active. When children are physically active, their muscles generate *heat* thereby increasing their *body temperature*. As their body temperature rises, their cooling mechanism - sweat - kicks in. When sweat evaporates, the body is cooled. Unfortunately, children get hotter than adults during physical activity and their body’s cooling mechanism is not as efficient as adults. If fluids aren’t replaced, children can become ***overheated***. We usually think about ***dehydration*** in the summer months when hot temperatures shorten the time it takes for children to become overheated. But keeping children well hydrated is just as important in the winter months. Additional clothing worn in the colder weather makes it difficult for sweat to evaporate, so the body does not cool as quickly. It does not matter if it’s January or July; thirst is not an indicator of fluid needs. Therefore, ***children must be encouraged to drink fluids even when they don’t feel thirsty***.

Managers and coaches should schedule drink breaks every 15 to 30 minutes during practices on hot days, and should encourage players to drink between every inning. During any activity water is an excellent fluid to keep the body well hydrated. It’s economical too! Offering flavored fluids like sport drinks or fruit juice can help encourage children to drink. Sports drinks should contain between 6 and 8 percent carbohydrates (15 to 18 grams of carbohydrates per cup) or less. If the carbohydrate levels are higher, the sports drink should be diluted with water. Fruit juice should also be diluted (1 cup juice to 1-cup water). Beverages high in carbohydrates like undiluted fruit juice may cause stomach cramps, nausea and diarrhea when the child becomes active. ***Caffeinated beverages (tea, coffee, colas) should be avoided*** because they are diuretics and can dehydrate the body further. ***Avoid carbonated drinks***, which can cause gastrointestinal distress and may decrease fluid volume.

# Muscle, Bone, or Joint Injuries

**Symptoms of Serious Muscle, Bone, or Joint Injuries**

Always suspect a serious injury when the following signals are present:

* Significant deformity
* Bruising and swelling
* Inability to use the affected part normally
* Bone fragments sticking out of a wound
* Victim feels bones grating; victim felt or heard a snap or pop at the time of injury
* The injured area is cold and numb
* Cause of the injury suggests that the injury may be severe.

If any of these conditions exists, call **9-1-1** immediately and administer care to the victim until the paramedics arrive.

**Treatment for muscle or joint injuries:**

* If ankle or knee is affected, do not allow victim to walk. Loosen or remove shoe; elevate leg.
* Protect skin with thin towel or cloth. Then apply cold, wet compresses or cold packs to affected area. Never pack a joint in ice or immerse in icy water.
* If a twisted ankle, do not remove the shoe -- this will limit swelling.
* Consult professional medical assistance for further treatment if necessary.

**Treatment for fractures:**

Fractures need to be splinted in the position found and no pressure is to be put on the area. Splints can be made from almost anything; rolled up magazines, twigs, bats, etc.

**Treatment for broken bones:**

Once you have established that the victim has a broken bone, and you have called **9-1-1**, all you can do is comfort the victim, keep him/her warm and still and treat for shock if necessary.

# Head and Neck Injuries

***Concussion Protocol***

WHAT IS A CONCUSSION?

* A concussion is an injury that changes how the cells in the brain normally work.
* A concussion is caused by a blow to the head or body that causes the brain to move rapidly inside the skull. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.
* Concussions can also result from a fall or from players colliding with each other or with obstacles, such as a goalpost.
* The potential for concussions is greatest in athletic environments where collisions are common.
* Concussions can occur in any organized or unorganized sport or recreational activity.
* As many as 3.8 million sports- and recreation-related concussions occur in the United States each year.

THE FACTS

* A concussion is a brain injury.
* All concussions are serious.
* Concussions can occur without loss of consciousness.
* Concussions can occur in any sport.
* Recognition and proper management of concussions when they first occur can help prevent further injury or even death.

RECOGNIZING A POSSIBLE CONCUSSION

To help recognize a concussion, you should watch for the following two things among your athletes:

* A forceful blow to the head or body that head results in rapid movement of the head.
* Any change in the athlete’s behavior, thinking, or physical functioning.

(See the signs and symptoms of concussion.)

SIGNS AND SYMPTOMS

**Signs observed by coaching staff:**

* Appears dazed or stunned
* Is confused about assignment or position
* Forgets sports plays
* Is unsure of game, score, or opponent
* Moves clumsily
* Answers questions slowly
* Loses consciousness (even briefly)
* Shows behavior or personality changes
* Can’t recall events prior to hit or fall
* Can’t recall events after hit or fall

**Symptoms reported by athlete:**

* Headache or “pressure” in head
* Nausea or vomiting
* Balance problems or dizziness
* Double or blurry vision

**Signs and symptoms:**

* Sensitivity to light
* Sensitivity to noise
* Feeling sluggish, hazy, foggy, or groggy
* Concentration or memory problems
* Confusion
* Does not “feel right”

ACTION PLAN

**What should a coach do when a concussion is suspected?**

* Remove the athlete from play.

- Look for the signs and symptoms of a concussion if your athlete has experienced a bump or blow to the head.

- Athletes who experience signs or symptoms of concussion should not be allowed to return to play.

- When in doubt, keep the athlete out of play.

* Ensure that the athlete is evaluated right away by an appropriate health care professional.
* Do not try to judge the severity of the injury yourself. Health care professionals have a number of methods that they can use to assess the severity of concussions. As a coach, recording the following information can help health care professionals in assessing the athlete after the injury:

- Cause of the injury and force of the hit or blow to the head

- Any loss of consciousness (passed out/knocked out) and if so, for how long

- Any memory loss immediately ○ following the injury

- Any seizures immediately following the injury

- Number of previous concussions (if any)

* Inform the athlete’s parents or athletes’ guardians about the possible concussion and direct them to the Parent Concussion Info sheet available on the RLL web site).
* Make sure they know that the athlete should be seen by a health care professional experienced in evaluating for concussion.
* Allow the athlete to return to play only with permission from a health care professional with experience in evaluating for concussion.
* A repeat concussion that occurs before the brain recovers from the first can slow recovery or increase the likelihood of having long-term problems.
* Prevent common long-term problems and the rare second impact syndrome by delaying the athlete’s return to the activity until the player receives appropriate medical evaluation and approval for return to play.

LICENSED HEALTH CARE PROVIDERS

What licensed health care providers are trained in the evaluation and treatment of concussions/brain injuries and authorized to allow the athlete to return to play?

* Doctors (Medical MD)
* Doctor of Osteopathy (DO)
* Advanced Registered Nurse Practitioner (ARNP)
* Physician’s Assistant (PA)
* Licensed Certified Athletic Trainers (ATC)

If you think your athlete has sustained a concussion...take him/her out of play and seek the advice of a health care professional experienced in evaluating for concussion.

***Head and Spine Injuries***

**When to suspect head and spine injuries:**

* A fall from a height greater than the victim’s height.
* Any bicycle, skateboarding, rollerblade mishap
* A person found unconscious for unknown reasons.
* Any injury involving severe blunt force to the head or trunk, such as from a bat or line drive baseball.
* Any injury that penetrates the head or trunk, such as impalement.
* Any person struck by a motor vehicle.
* Any injury in which a victim’s helmet is broken, including a motorcycle, batting helmet, industrial helmet.
* Any incident involving a lightning strike.

**Signals of head and spine injuries:**

* Changes in consciousness
* Severe pain or pressure in the head, neck, or back
* Tingling or loss of sensation in the hands, fingers, feet, and toes
* Partial or complete loss of movement of any body part
* Unusual bumps or depressions on the head or over the spine
* Blood or other fluids in the ears or nose
* Heavy external bleeding of the head, neck, or back
* Seizures
* Impaired breathing or vision as a result of injury
* Nausea or vomiting
* Persistent headache
* Loss of balance
* Bruising of the head, especially around the eyes and behind the ear

**General care for head and spine injuries:**

1. Call 9-1-1 immediately.
2. Minimize movement of the head and spine.
3. Maintain an open airway.
4. Check consciousness and breathing.
5. Control any external bleeding.
6. Keep the victim from getting chilled or overheated until paramedics arrive and take over care

***Contusion to Sternum***

Contusions to the Sternum are usually the result of a line drive that hits a player in the chest. These injuries can be very dangerous because if the blow is hard enough, the heart can become bruised and start filling up with fluid. Eventually the heart is compressed and the victim dies. Do not downplay the seriousness of this injury.

1. If a player is hit in the chest and appears to be all right, urge the parents to take their child to the hospital for further examination.
2. If a player complains of pain in his chest after being struck, immediately call 9-1-1 and treat the player until professional medical help arrives.
3. A rare condition can occur whereby the athlete is struck in the sternum with a pitched or batted ball causing a heart rhythm disturbance called commotio cordis. Children aged 5 to 15 are uniquely susceptible to this injury due to their relatively elastic chest walls. This condition is usually fatal unless proper treatment is instituted immediately with CPR and more importantly automated external defibrillation (AED). The Aldrich and Fitzgerald fields have AED units installed.
4. A telephone has been installed in the concession area of the Fitzgerald field.

# Cuts and Bleeding

Before initiating any First Aid to control bleeding, be sure to wear the **latex gloves** included in your First-Aid Kit in order to avoid contact of the victim’s blood with your skin.

If a victim is bleeding,

1. **Act quickly**. Have the victim lie down. Elevate the injured limb higher than the victim’s heart unless you suspect a broken bone.
2. **Control bleeding** by applying direct pressure on the wound with a sterile pad or clean cloth.
3. If bleeding is controlled by direct pressure, **bandage firmly** to protect the wound. Check pulse to be sure the bandage is not too tight.

***Nose Bleed***

To control a nosebleed, have the victim lean forward and pinch the nostrils together until bleeding stops.

***Bleeding On the Inside and Outside of the Mouth***

To control bleeding inside the cheek, place folded dressings inside the mouth against the wound. To control bleeding on the outside, use dressings to apply pressure directly to the wound and bandage so as not to restrict.

***Infection***

To prevent infection when treating open wounds you must:

**CLEANSE**... the wound and surrounding area gently with mild soap and water or an antiseptic pad; rinse and blot dry with a sterile pad or clean dressing.

**TREAT**... to protect against contamination with ointment supplied in your First-Aid Kit.

**COVER**... to absorb fluids and protect wound from further contamination with Band-Aids, gauze, or sterile pads supplied in your First-Aid Kit. (Handle only the edges of sterile pads or dressings)

**TAPE**... to secure with First-Aid tape (included in your First-Aid Kit) to help keep out dirt and germs.

***Deep Cuts***

If the cut is deep, stop bleeding, bandage, and encourage the victim to get to a hospital so he/she can be stitched up. **Stitches decrease the severity of scars**.

***Dismemberment***

If part of the body has been torn or cut off, try to find the part and wrap it in sterile gauze or any clean material, such as a washcloth. Put the wrapped part in a plastic bag. Keep the part cool by placing the bag on ice, if possible, but do not freeze. Be sure the part is taken to the hospital with the victim. Doctors may be able to reattach it.

***Penetrating Objects***

If an object, such as a knife or a piece of glass or metal, is impaled in a wound:

1. **Do not** remove it.
2. Place several dressings around the object to keep it from moving.
3. Bandage the dressings in place around the object.
4. If an object penetrates the chest and victim complains of discomfort or pressure, quickly loosen bandage on one side and reseal. Watch carefully for recurrence. Repeat the procedure if necessary.
5. Treat for shock if needed (see “Care for Shock” section).
6. Call 9-1-1 for professional medical care.

# Communicable Disease Procedures

1. Bleeding must be stopped, the openwound covered, and the uniform changed if there is blood on it before the athlete may continue.
2. Routinely use gloves to prevent mucous membrane exposure when contact with blood or other body fluids are anticipated (provided in first-aid kit).
3. Immediately wash hands and other skin surface if contaminated with blood.
4. Clean all blood contaminated surfaces and equipment.
5. Managers, coaches, and volunteers with open wounds should refrain from all direct contact until the condition is resolved.
6. Follow accepted guidelines in the immediate control of bleeding and disposal when handling bloody dressings, mouth guards and other articles containing body fluids.
7. Immediately wash hands and other skin surfaces if contaminated with blood with antibacterial soap.

8. There has been a great deal of publicity regarding the increased incidence of methicillin resistant staph aureus (MRSA) occurring in athletic teams. The bacteria has developed resistance to commonly used antibiotics and can become more virulent and difficult to treat. Proper handwashing, prompt cleaning of cuts and scrapes as well as not sharing towels and used clothing between athletes is important to decrease the risk of MRSA.

# Allergic Reactions and Insect Stings

The key in preventing allergic reactions is to know whether one of your players has any significant allergies. Food allergies are quite common in this age group. It is recommended that at one of the first practices players and parents be asked to reveal any allergies and communicate it to the rest of the team parents/families. Do not rely solely on the medical release forms. This is especially true at the levels where post game snacks are supplied by the parents. Highly allergic players usually have an “Epi-Pen” injection supplied to them by their personal physician and it should be brought to games and practices.

If a known highly sensitive person is exposed, do not wait for allergic symptoms to appear. Get professional medical help immediately. Call **9-1-1**. If breathing difficulties occur, start rescue breathing techniques; if pulse is absent, begin CPR or find someone who knows CPR to begin treatment. The Fitzgerald and Aldrich fields have an automated external defibrillator unit (AED). As of 2022, the Majors and AAA Minors coaches are required to receive training in CPR and AED usage.

**Symptoms:**

Signs of allergic reaction may include: nausea; severe swelling; itching, breathing difficulties; bluish face, lips and fingernails; shock or unconsciousness.

# Pitching Recommendations for Young Baseball Players

 *“We've got an epidemic going on.”*

Dr. James Andrews,
a nationally prominent sports orthopedist
quoted in *The New York Times*

* As many as 58% of children and adolescents between the ages of 11 and 18 experience *elbow injuries* during or after pitching in organized games.

*American Sports Medicine Institute*

* A study of U.S. collegiate males determined that 15% of students who pitched in youth baseball felt their ability to throw in college was hindered or hampered by pain, tenderness or limitation of movement as a result of youth baseball pitching.

*American Sports Medicine Institute*

* a recent survey found an injury incidence of 40.1% in 172 9- to 12-year-old pitchers who were followed for 1 year

*Medicine & Science in Sports & Exercise.
30(5) Supplement:4, May 1998*

**A RECENT ASMI SURVEY HAS
DEMONSTRATED THE FOLLOWING:**

* **A significantly higher risk of elbow injury occurred after pitchers reached 50 pitches/outing.**
* **A significantly higher risk of shoulder injury occurred after pitchers reached 75 pitches/outing.**
* **In one season, a total of 450 pitches or more led to cumulative injury to the elbow and the shoulder.**

***Pitch Count***

Many reports have been done that suggest a substantial increase in the number of kids injured from excessive use of their arms. Children in our local area of Ridgefield have caused permanent injury by overuse.

***Pitch count does matter***.

Remember, in the major leagues, a pitcher is removed after approximately 100 pitches. ***A child cannot be expected to perform like an adult!***

Little League managers and coaches are usually quick to teach their pitchers how to get movement on the ball. Unfortunately, the technique that older players use is not appropriate for children thirteen (13) years and younger. The snapping of the arm used to develop this technique will most probably lead to serious injuries to the child as he/she matures. Arm stress during the acceleration phase of throwing affects both the inside and the outside of the growing elbow. On the inside, the structures are subjected to distraction forces, causing them to pull apart. On the outside, the forces are compressive in nature with different and potentially more serious consequences.

The key structures on the inside (or medial) aspect of the elbow include the tendons of the muscles that allow the wrist to flex and the growth plate of the medial epicondyle (“Knobby” bone on the inside of the elbow). The forces generated during throwing can cause this growth plate to pull away (avulse) from the main bone. If the distance between the growth plate and main bone is great enough, surgery is the only option to fix it. This growth plate does not fully adhere to the main bone until age 15! Similarly, on the outside (or lateral) aspect of the elbow, the two bony surfaces can be damaged by compressive forces during throwing. This scenario can lead to a condition called Avascular Necrosis or Bone Cell Death as a result of compromise of the local blood flow to that area. This disorder is permanent and often leads to fragments of the bone breaking away (loose bodies) which float in the joint and can cause early arthritis. This loss of elbow motion and function often precludes further participation.

Studies have demonstrated that curveballs cause most problems at the inside of the elbow due to the sudden contractive forces of the wrist musculature. Fastballs, on the other hand, place more force at the outside of the elbow. Sidearm delivery, in one study, led to elbow injuries in 74% of pitchers compared with 27% in pitchers with a vertical delivery style.

The American Academy of Orthopedic Surgeons recommends limiting the number of innings that young baseball pitchers play to a maximum of 4 - 10 a week. While there is no concrete guideline for the number of pitches allowed, reasonable limits are 80-100 pitches in a game and 30 to 40 pitches in a single practice session. Any persistent pain weakness or loss of motion should disqualify a child from playing until these findings resolve or are evaluated by a physician.

Attached is LL’s policy as well as local suggestions towards pitcher safety in youth little league.

# Little League (LL) International Pilot Pitching Policy (updated 2008)

|  |  |  |  |
| --- | --- | --- | --- |
| Age | Maximum pitches per Game | **Suggested**Maximum pitches per Game | **ASMI Recommendation per season** |
| 7-89-10 | 5075 | 5050 | 1,000 |
| 11 / 12 | 85 | 60 / 70 | 1,000 |

**Pitchers league ages 7 through 16 must adhere to the following rest requirements (rules effective for the 2008 season):**

* If a player pitches 61 or more pitches in a day, three (3) calendar days of rest must be observed PLUS a game must be observed.
* If a player pitches 41 - 60 pitches in a day, two (2) calendar days of rest must be observed PLUS a game must be observed.
* If a player pitches 21 - 40 pitches in a day, one (1) calendar day of rest must be observed.
* If a player pitches 1-20 pitches in a day, no (0) calendar days of rest must be observed.

For more information please go to the ASMI report on the USA baseball website:

<http://graphics.fansonly.com/photos/schools/usab/genrel/auto_pdf/youth-injuries.pdf>

(**Suggestion**: When a pitcher is removed from a current game refrain from putting him/her at frequent throwing positions on the field such as shortstop and catcher. On the first day after a pitching appearance (especially if more than 20 pitches are thrown in a game) if you have a game the following day place that pitcher from the previous day in a minimal throwing position on the field (e.g. 1st Base or Right field) and/or minimize throwing motions in the first 24 hours after a pitching appearance. After the first 24 hours, a pitcher should begin throwing via short and long tossing drills to maintain arm flexibility and continual arm endurance.

**New rules for 2008 Little League and Ridgefield Little League**

1. The pitcher may not move from the pitcher to catcher during any game after throwing more than 20 pitches. The catcher has the second most common overuse injury related to throwing. Studies have shown that moving from catcher to pitcher does not raise the same concerns.
2. The automatic intentional walk is acceptable. If a pitcher wishes to walk a batter four pitches are added to a pitchers count but do not need to be thrown.

**Some RULES of Thumb for pitch counts:**

* Use a ramp-up approach by pitcher appearance. Start with a much lower pitch count early in the season and build up to the suggested maximum pitch count. Don’t assume your pitcher is ready on opening day with only a few practices to throw 85 pitches at 12 years old. Even if the pitcher looks strong to the naked eye and they have good control early in the season, give the pitcher real playing/bull-pen time to build up a level of strength.
* Another pitch count rule of thumb is to use a multiplier of “Age x 6.” For example, a pitcher who is 11 years old should throw a maximum of 11 x 6 or 66 total pitches. Again, take into consideration that you must build in practice and repetition throwing/conditioning to reach this level of pitches.

To minimize the risk of injury and maximize performance of youth baseball pitchers, there are several factors that all need to be considered: 1) Number of pitches thrown; 2) Types of pitches thrown; 3) Quality of mechanics; 4) Physical conditioning and preparation; 5) Nutrition and hydration; and 6) Genetic makeup.

**What to do after pitching in a game**

***Ice is a universal First-Aid treatment for minor sports injuries. Ice controls the pain and swelling. Pitchers should be taught how to ice their arms at the end of a game.***

***Suggested method is household ice in a Ziploc bag and general ace bandage wrapped around the sore part of the arm (usually the shoulder or elbow). Suggested duration for ice treatment is up to 15-20 minutes in each arm area. Generally, avoid using heat treatment following a pitching appearance.***

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# Emergency Treatment of Dental Injuries

**AVULSION (Entire Tooth Knocked Out)**

If a tooth is knocked out, place a sterile dressing directly in the space left by the tooth. Tell the victim to bite down. Dentists can successfully replant a knocked-out tooth if they can do so quickly and if the tooth has been cared for properly.

1. Avoid additional trauma to tooth while handling. **Do Not** handle tooth by the root. **Do Not** brush or scrub tooth. **Do Not** sterilize tooth.
2. If debris is on the tooth, gently rinse with water.
3. If possible, re-implant and stabilize by biting down gently on a towel or handkerchief. **Do only** if the athlete is alert and conscious.
4. If unable to re-implant:
Best - Place tooth in Hank’s Balanced Saline Solution, i.e. “Save-a-tooth.”
2nd best - Place tooth in milk. Cold whole milk is best, followed by cold 2% milk.
3rd best - Wrap tooth in saline soaked gauze.
4th best - Place tooth under victim’s tongue. **Do only** if athlete is conscious and alert.
5th best - Place tooth in cup of water.
5. **Time is very important.** Re-implantation within 30 minutes has the highest degree of success rate. **TRANSPORT IMMEDIATELY TO DENTIST.**

**LUXATION (Tooth in Socket, but Wrong Position)**

THREE POSITIONS –

**EXTRUDED TOOTH** - Upper tooth hangs down and/or lower tooth raised up.

1. Reposition tooth in socket using firm finger pressure.
2. Stabilize tooth by gently biting on towel or handkerchief.
3. **TRANSPORT IMMEDIATELY TO DENTIST**.

**LATERAL DISPLACEMENT** - Tooth pushed back or pulled forward.

1. Try to reposition tooth using finger pressure.
2. Victim may require local anesthetic to reposition tooth; if so, stabilize tooth by gently biting on towel or handkerchief.
3. **TRANSPORT IMMEDIATELY TO DENTIST**.

**INTRUDED TOOTH** - Tooth pushed into gum - looks short.

1. Do nothing - avoid any repositioning of tooth.
2. **TRANSPORT IMMEDIATELY TO DENTIST**.

**FRACTURE (Broken Tooth)**

1. If tooth is totally broken in half, save the broken portion and bring to the dental office as described under Avulsion, Item 4. Stabilize portion of tooth left in mouth be gently biting on a towel or handkerchief to control bleeding.
2. Should extreme pain occur, limit contact with other teeth, air or tongue. Pulp nerve may be exposed, which is extremely painful to athlete.
3. Save all fragments of fractured tooth as described under Avulsion, Item 4.
4. **IMMEDIATELY TRANSPORT PATIENT AND TOOTH FRAGMENTS TO DENTIST** in the plastic baggie supplied in your First-Aid kit.

***Do mouth guards prevent injuries?*** A mouth guard can prevent serious injuries such as concussions, cerebral hemorrhages, and incidents of unconsciousness, jaw fractures and neck injuries by helping to avoid situations where the lower jaw gets jammed into the upper jaw. Mouth guards are effective in moving soft issue in the oral cavity away from the teeth, preventing laceration and bruising of the lips and cheeks, especially for those who wear orthodontic appliances.

# Burns

***Care for Burns***

The care for burns involves the following 3 basic steps.

**Stop** the Burning -- Put out flames or remove the victim from the source of the burn.

**Cool** the Burn -- Use large amounts of cool water to cool the burned area. Do not use ice or ice water other than on small superficial burns. Ice causes body heat loss. Use whatever resources are available-tub, shower, or garden hose, for example. You can apply soaked towels, sheets or other wet cloths to a burned face or other areas that cannot be immersed. Be sure to keep the cloths cool by adding more water.

**Cover** the Burn -- Use dry, sterile dressings or a clean cloth. Loosely bandage them in place. Covering the burn helps keep out air and reduces pain. Covering the burn also helps prevent infection. If the burn covers a large area of the body, cover it with clean, dry sheets or other cloth.

***Chemical Burns***

If a chemical burn,

1. Remove contaminated clothing.
2. Flush burned area with cool water for at least 5 minutes.
3. Treat as you would any major burn (see above).

If an eye has been burned:

1. Immediately flood face, inside of eyelid and eye with cool running water for at least 15 minutes. Turn your head so water does not drain into the uninjured eye. Lift the eyelid away from the eye so the inside of the lid can also be washed.
2. If eye has been burned by a dry chemical, lift any loose particles off the eye with the corner of a sterile pad or clean cloth.
3. Cover both eyes with dry sterile pads, clean cloths, or eye pads; bandage in place.

# Lightning Facts and Safety Procedures

***WHEN YOU HEAR IT - CLEAR IT***

***WHEN YOU SEE IT - FLEE IT***

***Consider the following facts:***

* The average lightning strike is 6 - 8 miles long.
* The average thunderstorm is 6 -10 miles wide and travels at a rate of 25 miles per hour.

Once the leading edge of a thunderstorm approaches to within 10 miles, you are at immediate risk due to the possibility of lightning strikes coming from the storm’s overhanging anvil cloud. On the average, thunder can only be heard over a distance of 3 - 4 miles, depending on humidity, terrain, and other factors. This means that by the time you hear the thunder, you are already in the risk area for lightning strikes.

***“Flash-Bang” Method***

One way of determining how close a recent lightning strike is to you is called the “flash-bang” method. With the “flash-bang” method, a person counts the number of seconds between the sight of a lightning strike and the sound of thunder that follows it. Halt-play and evacuation should be called for when the count between the lightning flash and the sound of its thunder is 15 seconds or less.

***Rule of Thumb***

The ultimate truth about lightning is that it is unpredictable and cannot be prevented. Therefore, a manager, coach, or umpire who feels threatened by an approaching storm should stop play and get the kids to safety.

***Where to Go?***

No place is absolutely safe from the lightning threat, but some places are safer than others. Large enclosed shelters (substantially constructed buildings) are the safest (like our snack bars and press boxes). For the majority of participants, the best area for them to seek shelter is in a fully enclosed metal vehicle with the windows rolled up. If you are stranded in an open area and cannot get to shelter in a car, put your feet together, crouch down, and put your hands over your ears (to try and prevent eardrum damage). It is much safer to sit in an automobile than in the wooden dugouts at the fields.

***Where NOT to Go!!***

Avoid high places and open fields, isolated trees, unprotected gazebos, rain or picnic shelters, dugouts, flagpoles, light poles, bleachers (metal or wood), metal fences, and water.

***First Aid to a Lightning Victim***

Typically, the lightning victim exhibits similar symptoms as that of someone suffering from a heart attack. In addition to calling 911, the rescuer should consider the following:

* The first tenet of emergency care is “make no more casualties.” If the victim is in a high-risk area, open field, isolated tree, etc., the rescuer should determine if movement from that area is necessary - lightning can and does strike the same place twice. If the rescuer is at risk, and movement of the victim is a viable option, it should be done.
* If the victim is not breathing, start mouth to mouth resuscitation. If it is decided to move the victim, give a few quick breaths prior to moving them.
* Determine if the victim has a pulse. If no pulse is detected, start cardiac compressions as well

Note: CPR should only be administered by a person knowledgeable and trained in the technique.

***Cardiopulmonary Resuscitation (CPR)***

***Automated External Defibrillation***

Since 2007, Ridgefield Little League has implemented a comprehensive training program for treatment of catastrophic injuries. All coaches will be familiar with basic first aid. In addition, one coach and one manager from each Majors and AAA will be trained in CPR and the use of an automated external defibrillator (AED). This training is offered to the coaches before the start of the season and provides an enhanced level of safety for our players and spectators.

There is an AED unit in each of the concession stands at the Aldrich Field, Jensen Field and Fitzgerald Fields. Additionally, there is an AED unit in the orange equipment box located behind home plate at Scalzo field. Please see the following chart to remind trained volunteers on CPR and AED procedures.

***CPR/AED, First Aid & Fundamentals Training 2023***

It is required that all AAA and Majors teams have at least 1 individual, manager or coach, certified in CPR. For your convenience, Your Home CPR, located in the Kohl’s shopping center, is offering the 60-minute American Heart Association's Heartsaver CPR AED course to RLL Volunteers for a significant discount of $25 (cash or check accepted). Self-register for an available class by visiting [www.ScheduleCPR.com](http://www.schedulecpr.com/), select "Heartsaver CPR AED."  Classes will fill up quickly so please register for a class as soon as possible so you are ready for the season.

**SAFETY & FIRST AID TRAINING MEETING**

**All Managers and Coaches are required to attend the Safety & First Aid Training Meeting on or after March 23rd.**

Ridgefield Little League requires all managers and coaches to attend the Safety & First Aid Training Meeting each year.

**COACHING FUNDAMENTALS CLINICS**

**At least one representative from each team (manager or coach) must attend the Coaching Fundamentals Clinics to be held on:**

**Tee Ball, Rookies & A: RLL’s Coaching Fundamentals Clinics will be scheduled on or after April 1st**

**AA, AAA & Majors: RLL’s Coaching Fundamentals Clinics will be scheduled on or after April 1st**



# Storage Shed Procedures

The following applies to all of the storage sheds used by Ridgefield Little League and further applies to anyone who has been issued keys by Ridgefield Little League to use these sheds.

* Before the use of any machinery located in the shed (i.e., lawn mowers, weed whackers, lights, scoreboards, public address systems, etc.) please locate and read the written operating procedures for that equipment.
* All chemicals or organic materials stored in storage sheds shall be properly marked and labeled and stored in its original container if available.
* Any witnessed “loose” chemicals or organic materials within these sheds should be cleaned up and disposed of immediately to prevent accidental poisoning.
* Keep products in their original container with the labels in place.
* Use poison symbols to identify dangerous substances.
* Dispose of outdated products as recommended.
* Use chemicals only in well-ventilated areas.
* Wear proper protective clothing, such as gloves or a mask when handling toxic substances.

# Concession Stand Guidelines

***Keep It Clean: Concession Stand Tips***

From past experience, the US Centers for Disease Control and Prevention (CDC) list these circumstances as the most likely to lead to illness. Check this list to make sure your concession stand has covered these common causes of food borne illness.

* **Inadequate cooling and cold holding.**
* **Preparing food too far in advance for service.**
* **Poor personal hygiene and infected personnel.**
* **Inadequate reheating.**
* **Inadequate hot holding.**
* **Contaminated raw foods and ingredients.**

***Clean Hands for Clean Foods***

Since the staff at concession stands may not be professional food workers, it is important that they be thoroughly instructed in the proper method of washing their hands. The following may serve as a guide:

* **Use soap and warm water.**
* **Rub your hands vigorously as you wash them.**
* **Wash all surfaces including the backs of hands, wrists, between fingers and under fingernails.**
* **Rinse your hands well.**
* **Dry hands with a paper towel.**
* **Turn off the water using a paper towel, instead of your bare hands.**

***Wash your hands in this fashion before you begin work and frequently during the day, especially after performing any of these activities:***

* After touching bare human body parts other than clean hands and clean, exposed portions of arms.
* After using the restroom.
* After caring for or handling animals.
* After coughing, sneezing, using a handkerchief or disposable tissue.
* After handling soiled surfaces, equipment or utensils.
* After drinking, using tobacco, or eating.
* During food preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks.
* When switching between working with raw food and working with ready-to-eat food.
* Directly before touching ready-to-eat food or food contact surfaces.
* After engaging in activities that contaminate hands.

***‘12 Steps to Safe and Sanitary Food Service Events’***

**1. Menu.** Keep your menu simple, and keep potentially hazardous foods (meats, eggs, dairy products, protein salads, cut fruits and vegetables, etc.) to a minimum. Avoid using precooked foods or leftovers. Use only foods from approved sources, avoiding foods that have been prepared at home. *Complete control over your food, from source to service, is the key to safe, sanitary food service.*

**2. Cooking.** Use a food thermometer to check on cooking and holding temperatures of potentially hazardous foods. All potentially hazardous foods should be kept at 41º F or below (if cold) or 140º F or above (if hot). Ground beef and ground pork products should be cooked to an internal temperature of 155º F, poultry parts should be cooked to 165º F. *Most food borne illnesses from temporary events can be traced back to lapses in temperature control.*

**3. Reheating.** Rapidly reheat potentially hazardous foods to 165º F. Do not attempt to heat foods in crock pots, steam tables, over sterno units or other holding devices. *Slow-cooking mechanisms may activate bacteria and never reach killing temperatures.*

**4. Cooling and Cold Storage.** Foods that require refrigeration must be cooled to 41º F as quickly as possible and held at that temperature until ready to serve. To cool foods down quickly, use an ice water bath (60% ice to 40% water), stirring the product frequently, or place the food in shallow pans no more than 4 inches in depth and refrigerate. Pans should not be stored one atop the other and lids should be off or ajar until the food is completely cooled. Check the temperature periodically to see if the food is cooling properly. *Allowing hazardous foods to remain unrefrigerated for too long has been the number ONE cause of food borne illness.*

**5. Hand Washing. *Frequent and thorough hand washing remains the first line of defense in preventing food borne disease.*** The use of disposable gloves can provide an additional barrier to contamination, but they are no substitute for hand washing!

**6. Health and Hygiene.** Only healthy workers should prepare and serve food. Anyone who shows symptoms of disease (cramps, nausea, fever, vomiting, diarrhea, jaundice, etc.) or who has open sores or infected cuts on the hands should not be allowed in the food concession area. Workers should wear clean outer garments and should not smoke in the concession area. The use of hair restraints is recommended to prevent hair ending up in food products.

**7. Food Handling.** Avoid hand contact with raw, ready-to eat foods and food contact surfaces. Use an acceptable dispensing utensil to serve food. *Touching food with bare hands can transfer germs to food.*

**8. Dishwashing.** Use disposable utensils for food service. Keep your hands away from food contact surfaces, and never reuse disposable dishware. ***Ideally***, dishes and utensils should be washed in a four-step process:

1. Washing in hot soapy water;

2. Rinsing in clean water;

3. Chemical or heat sanitizing; and

4. Air drying.

**9. Ice.** Ice used to cool cans/bottles should not be used in cup beverages and should be stored separately. Use a scoop to dispense ice; never use the hands. *Ice can become contaminated with bacteria and viruses and cause food borne illness.*

**10. Wiping Cloths.** Rinse and store your wiping cloths in a bucket of sanitizer (example: 1 gallon of water and 12 teaspoons of chlorine bleach). Change the solution every two hours. *Well sanitized work surfaces prevent cross-contamination and discourage flies.*

**11. Insect Control and Waste.** Keep foods covered to protect them from insects. Store pesticides away from foods. Place garbage and paper wastes in a refuse container with a tight-fitting lid. Dispose of wastewater in an approved method (do not dump it outside). All water used should be potable water from an approved source.

**12. Food Storage and Cleanliness.** Keep foods stored off the floor at least six inches. After your event is finished, clean the concession area and discard unusable food.

***Field Safety Inspections 2023***

Inspections of all fields are conducted by the Director of Fields and repairs/upgrades are made in accordance with his recommendations.