January-February 2004 · Volume 11/Number 1

ASAP news

Continuing the Little League tradition of making it "safer for the kids."

Accidents Happen

Keep them from happening to you!

In 2002, Little League saw the worst types of avoidable injuries have largely been eliminated to players and volunteers. However, expanding use of safety bases and reduced impact balls as well as other safety equipment could help reduce even more of the injuries listed below.

The analysis compiled by LLB staff shows that in 2002, 31 players and seven adults were seriously injured, requiring extensive treatment for their injuries. This compares to 28 total serious injuries in 2001, but is still a reduction over 2000, when 45 players and volunteers were seriously injured. Compared to 1994-1996, when ASAP was just starting, Little League averaged 59 severe injuries a year to players and volunteers.

"It's difficult for people in the local league to appreciate their safety efforts, because it's difficult to celebrate the injury that doesn't occur," said Dan Kirby, Risk Management Director at LLB. "But local league officials are making a huge impact on Little League."

"Looking at these figures since the program began, we've seen almost a 50 percent reduction in the worst injuries, and overall injuries are reduced by 75 percent, so those who are in ASAP should keep up their good work. And for the half of the leagues who haven't prepared a safety plan before, isn't it time?" Kirby asked. "Your efforts are important. You are protecting your spouse or child or grandchild from being injured."

In 2002, the highest number of injuries occurred because of collisions between players, most between defensive players. Ten of the 31 serious player injuries were due to collisions, resulting in five fractured legs, three fractured ankles, a fractured nose; torn ACL, and a fractured wrist.

The second highest type involved collisions with solid bases, causing seven major injuries. Six players were injured sliding into a base, causing three fractured ankles, two fractured legs, and a sprained back. The seventh was diving back to base, causing a fractured elbow.

2002 Serious Injuries	
Player Collisions	10
Sliding Injuries	7
Falling Injuries	5
Hit By Pitched Ball	4
Hit By Thrown/Swung Bat	3
Work-Related	3
Hit By Batted Ball	2
Running Injuries	2
Hit By Thrown Ball	1
Pitching Injury	1
Total	**38**

Five people were seriously injured after falling. The falls caused four fractured wrists (one adult) and a head injury.

Four players were injured by pitched balls while batting: a fractured orbit (bones around eye); a facial fracture; a fractured hand; and a fractured arm.

Adults were injured in three work-related accidents while helping their leagues: Broken leg; broken finger; and injured knee.

Three people were seriously injured by bats: An adult was hit in the head while in the coaching box, and a player suffered a fractured nose, both after being hit by thrown bats; a Junior player suffered a concussion by a swung bat by the on-deck batter, while going back to the dug out.

Only two players were seriously injured from batted balls: both were hit in the face, with one suffering a broken jaw and the other dental injuries.

Two people were also injured running: an adult tore the meniscus in his knee running at practice; and a player dislocated his knee chasing down a ball. Finally, one player received a fractured skull by a thrown ball; and a player suffered a fractured elbow while pitching.

Look at these injuries for ways to educate coaches and improve player training: Call for balls to avoid collisions; improve sliding techniques; stretch before playing; drop bats, and have a designated player retrieve them. In general, teach proper defensive ball skills and techniques. This will help protect both batters and fielders.

And always teach players to pay attention to the game, whether they are on the bench or on the field, to watch for potential risks and take the appropriate action.

First Aid Clinics

Requirement 6

"Thanks for getting back to me in a timely fashion. The outline would be great!!! I think I will have had the clinic by the time the next newsletter comes out. As far as format and instructors, I am all set. One of the local firefighters is also an EMT. He did the clinic last year. It was a HUGE success. Stoughton Little League has been around for nearly 50 years and we have never had a safety plan. It is amazing how we survived without it! Kudos to Williamsport and Musco Lighting for ASAP's success. I should be able to formulate a clinic with whatever outline you send."

Thank You,
Paul McKeen
Stoughton, MA
District 8

First, you should know Little League is phasing out the Emergency Management Training Program. However, even without the Emergency Management Training Program, you can put together a quality first aid training class to meet the requirements of first aid training for your coaches and managers. You don't have to follow the specifics of any set program, just get the PRICES – Protection, Rest, Ice, Compression, Elevation, and Support (or RICE or PRICE, whatever you use) – idea into participants' heads and talk about the specifics of first aid and injury prevention for specific baseball/softball injuries.

Start with basic terminology (contusion, laceration, etc.), and give the most up-to-date techniques for preventing sports injuries. Help attendees understand and differentiate between mild, moderate and severe injuries and the appropriate actions to take in each category. Teach appropriate first aid techniques for the injuries they will encounter.

Basic issues with baseball/softball would be:

- Contusions
- Muscle pulls and strains
- Over-use injuries
- Sprains
- Fractures
- Injuries to small joints
- Facial injuries
- Injuries to teeth
- Eye injuries
- Insect bites and stings
- Heat illness
- Triage and Emergency Management

Help design an emergency plan for your league when severe injuries occur, and tell the managers/coaches what their role is in that plan:

- Make sure managers/coaches stop all play to protect the player from further injury, as well as those not being closely monitored due to the focus on the injured player.
- Check player's breathing, pulse and alertness to immediately judge the seriousness of the injury:
  - · If necessary, send someone to call 9-1-1 or get an ambulance or EMS.
  - · Call the player's parents
  - · Send someone to nearest intersection to direct emergency services to your location
  - · Review the Medical Release form for any important information/warnings about medical conditions the player may have
- Evaluate the injury:
  - · Can player be moved off field?
  - · If not, clear area around player and begin examination;
  - · If so, move player to sideline for closer examination;
  - · Determine if player can return to play or needs first aid.
- Give the appropriate first aid for the injury.
- Turn over care to professionals when they arrive and help as directed.
- If parents are not available, go with player to treatment center with ambulance; turn over team to authorized coach.
- If emergency medical treatment isn't required, urge player and parents to see a doctor for a proper diagnosis and treatment plan.
- Record the injury on an injury report.
- Follow up with the player until injury is healed and player can return to play.
- Get medical release prior to allowing player to return, if formal treatment was required.

You should have medical professionals available either on-site or at most a phone call away — as well as a method to reach them, by cell phone or phone at the field — for severe or life-threatening injuries.

And finally, help the coaches/managers to understand specific techniques to determine whether an injured player is ready to practice and play again; in some cases this may require a doctor's release. The evaluation process involves determining whether injuries are mild, moderate or severe, and should address what to do in each case. The evaluation includes classifying injuries using symptoms and signs, with appropriate looking, listening and careful feeling and, if appropriate, moving of the injured part.

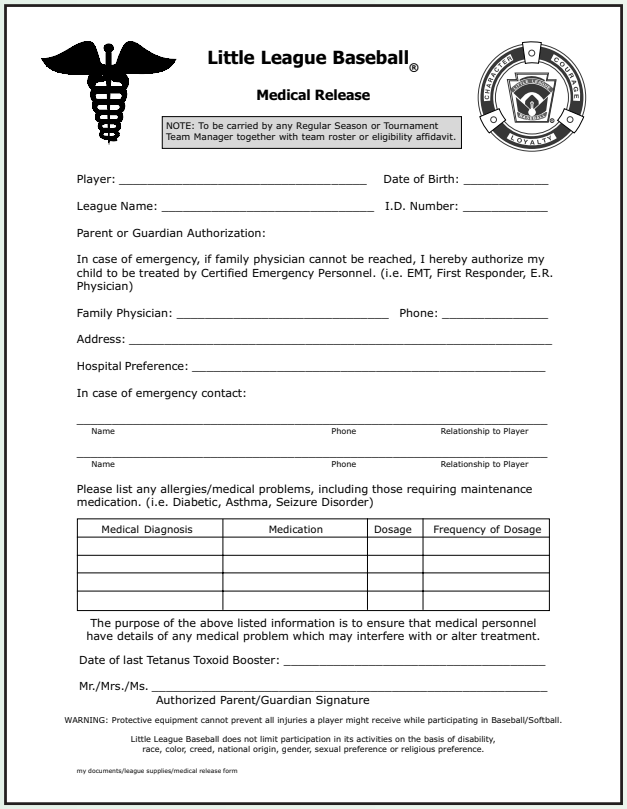
In evaluating fresh injuries, remember the three types of motion:

- Active motion – Player is able to move the part themselves,
- Active assistive motion – Player is able to move with a little help from you; watch for warning signs like the player telling you it hurts to move), and
- Passive motion – the player's injured part is moved by someone else; be especially cautious with passive motion that you do not make the injury worse.

Look for disability (the player can't use injured part); this is the most serious injury. If a player sprains his ankle, but can still limp around, it may be mild or moderate; if he can't get up, it is probably severe. Look for swelling, the

continued on page 3

Medical Release Form



Little League Baseball®

Medical Release

NOTE: To be carried by any Regular Season or Tournament Team Manager together with team roster or eligibility affidavit.

Player: _____ Date of Birth: _____

League Name: _____ I.D. Number: _____

Parent or Guardian Authorization:

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel. (i.e. EMT, First Responder, E.R. Physician)

Family Physician: _____ Phone: _____

Address: _____

Hospital Preference: _____

In case of emergency contact:

_____
Name Phone Relationship to Player

_____
Name Phone Relationship to Player

Please list any allergies/medical problems, including those requiring maintenance medication. (i.e. Diabetic, Asthma, Seizure Disorder)

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Date of last Tetanus Toxoid Booster: _____

Mr./Mrs./Ms. _____
Authorized Parent/Guardian Signature

WARNING: Protective equipment cannot prevent all injuries a player might receive while participating in Baseball/Softball.

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

my documents/league supplies/medical release form

Whether regular season or tournament games or practices, your managers need to carry all their players' Medical Releases. While just as critical for teams in tournament play, the forms are just as important during the regular season.

Most hospitals will not treat a player who does not have a life-threatening injury without one. Imagine if your manager has to accompany a player with a broken leg to the hospital because the parents weren't at the game or practice. Without a Medical Release it's likely to be a long wait with a suffering player as the manager tries frantically to reach them to approve medical treatment.

Make sure your league has all players' Medical Releases, and the manager carries the team's forms with him or her everywhere. Then if a parent isn't at the field when an accident happens, the only call that will really matter is to 9-1-1.

First Aid Clinics Outline continued from page 2

more immediate and large the swelling, the more serious the injury, because swelling on outside means bleeding on inside. Also, a noticeable deformity means a serious injury. If the body part doesn't look the way it did before the accident, something's wrong. Consider unconsciousness or any eye injury as a serious situation, in the category of severe injuries, until you are assured otherwise by a medical professional.

Use the PRICES guide for treating injuries:

P – Protection

R – Rest

I – Ice

C – Compression

E – Elevation

S – Support

In conclusion, ask for managers/coaches to consider how to prevent injuries:

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

This summarizes 62 pages into just a few hundred words, so you're going to want to elaborate on all the proper techniques in dealing with the different injury types and how to treat them effectively, as well as what NOT to do in any given circumstances. And remember, if anyone is ever in doubt to the nature or seriousness of an injury, they should NOT attempt treatment; a health care professional should be consulted immediately.

Finally, remind all managers and coaches to carefully evaluate all injuries and ensure the child does not require professional care. It's not worth risking a child's health just to continue the game.

Concession Stand Tips

SAFETY FIRST

Requirement 9

12 Steps to Safe and Sanitary Food Service Events: The following information is intended to help you run a healthful concession stand. Following these simple guidelines will help minimize the risk of foodborne illness. This information was provided by District Administrator George Glick, and is excerpted from "Food Safety Hints" by the Fort Wayne-Allen County, Ind., Department of Health.

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 foodborne 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 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 foodborne illness.

5. Hand Washing.

Frequent and thorough hand washing remains the first line of defense in preventing foodborne 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. Wash 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 foodborne illness.

10. Wiping Cloths.

Rinse and store your wiping cloths in a bucket of sanitizer (example: 1 gallon of water and 1⁄2 teaspoon 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.

13. Set a Minimum Worker Age.

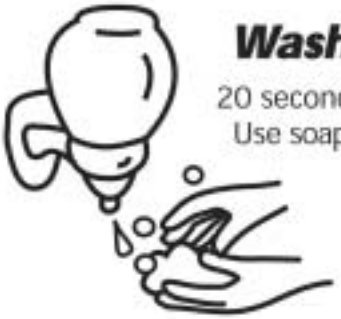
Leagues should set a minimum age for workers or to be in the stand; in many states this is 16 or 18, due to potential hazards with various equipment.

Safety plans must be postmarked no later than May 1, 2004.

Volunteers Must Wash Hands

HOW

Wet
warm water



Wash
20 seconds
Use soap

Rinse

Dry
Use single-service paper towels

Gloves

WHEN

Wash your hands before you prepare food or as often as needed.

Wash after you:

- use the toilet
- touch uncooked meat, poultry, fish or eggs or other potentially hazardous foods
- interrupt working with food (such as answering the phone, opening a door or drawer)
- eat, smoke or chew gum
- touch soiled plates, utensils or equipment
- take out trash
- touch your nose, mouth, or any part of your body
- sneeze or cough

Do not touch ready-to-eat foods with your bare hands.

Use gloves, tongs, deli tissue or other serving utensils.

Remove all jewelry, nail polish or false nails unless you wear gloves.

Wear gloves

when you have a cut or sore on your hand
when you can't remove your jewelry

If you wear gloves:

- wash your hands before you put on new gloves

Change them:

- as often as you wash your hands
- when they are torn or soiled

Developed by UMass Extension Nutrition Education Program with support from U.S. Food & Drug Administration in cooperation with the MA Partnership for Food Safety Education. United States Department of Agriculture Cooperating. UMass Extension provides equal opportunity in programs and employment.

UMASS EXTENSION

Wear ALL Catcher's Equipment

Requirement 13

"Since Austin's name and injury have come up again on this (Safety Officer Email List Server), I thought I would update you on his recovery. Kevin Hunter, the umpire consultant from the District that Austin played in, posted this today on the umpires (email) group."

Clay Berry
District Administrator
California District 33

For those of you who weren't following this (tragedy), last year at about this time, in a practice, (a catcher named) Austin, (in a Florida) Little League, was hit in the left temple by a thrown ball during infield practice. Austin SHOULD have been wearing a catcher's helmet, but wasn't, and was looking the other way when a throw came in from left field. Austin was in a coma for months as a result of the injury.

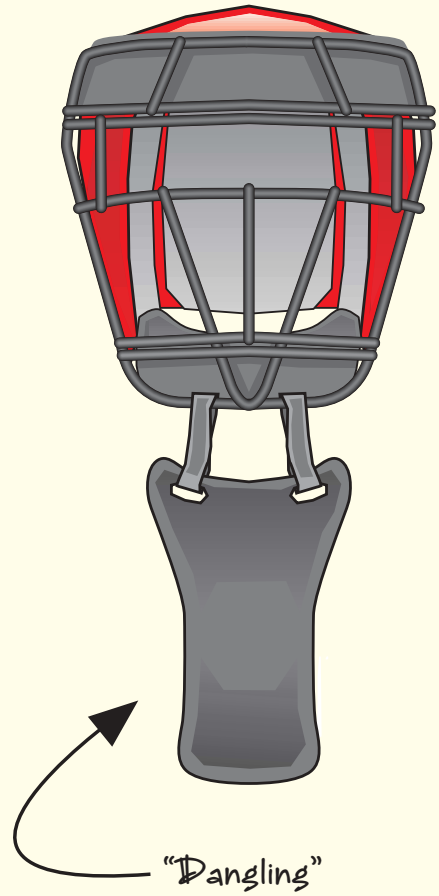
Austin, now age 12, is still making a slow recovery. He is basically all there mentally, but still suffers physical disability as a result of the brain damage he suffered from the accident. His right arm and right leg are both less mobile and coordinated than his left, and he still limps somewhat. He is very up-beat, and pragmatic about the accident - it was just 'something that happened.' Right now, his goal is to strengthen his arm to the point that he can do 35 pushups.

Prior to the accident, Austin was a star athlete in both baseball and football. It's not clear how close to "normal" he will ever recover physically. A tragic accident — and a preventable one.

Any time you see a catcher catching infield practice, whether in practice or before a game, I implore you to make sure he/she is wearing a helmet per Rule 1.17: "All catchers must wear a mask, 'dangling' type throat protector and catcher's helmet during infield/outfield practice, pitcher warm-up and games."

Kevin Hunter
Umpire Consultant
Florida District 9
Fort Myers, F L

(Editor's Note: For Austin's privacy, his last name and league have been omitted. We are all thankful he is recovering.)



Make Sure They Are Safe!

REMEMBER:

Catchers must wear helmets during warm-ups and infield/outfield practice.

RULE 1.17

"...All catchers must wear a mask, 'dangling' type throat protector and catcher's helmet during infield/outfield practice, pitcher warm-up and games."

Copy and post at dugouts.

Comotio Cordis

"I am now and have been the Safety Officer for the Thompsonville Little League in Enfield,Connecticut for 12 years. I also have been an EMT for 10 years, and a CPR and First Aid instructor for the American Heart Association for seven years. In the past few seasons,we have been hearing about these kids getting hit in the chest with a baseball thrown by their coaches and/or parents, throwing them into cardiac arrest. Last year, I found an article in Emergency Medical Services magazine that I thought was great, and applied potentially fatal injury in our kids. Please feel free to pass it on, and use this information when considering new rules pertaining to the use of protective equipment for the players, and guidelines for the staff."

Ken Maltese, Safety Officer/Secretary
Thompsonville Little League
Enfield, Connecticut

When Sudden Death Isn't a Sporting Term

By Robert N. Anderson, EMT-IV, RN, CCRN CEN, CFRN

(Reprinted with permission from the July, 2003 issue of EMS Magazine)

You are sitting in the bleachers awaiting the start of a baseball game on a beautiful July day. The "Boys of Summer", a local Little League group are warming up before the game by throwing baseballs to one another. You watch the pair closest to you, as one 11-year old tosses the ball to another. For whatever reason, the recipient misses the catch, and the ball strikes him in the chest. He looks blankly at the ball for a second or two, and then simply falls over. At first, his friends tell him to quit goofing around. Finally realizing something is amiss, the coach rushes over and yells, "Help! Someone call 911!" You run to the field and quickly assess the boy's ABC's. He is pulseless and not breathing and you begin CPR. What just happened?

Defining Comotio Cordis

Comotio cordis, literally concussion of the heart, can cause sudden cardiac death of a young person following a blunt impact to the chest. On autopsy, comotio cordis is identified when there is an absence of cardiac injury, and underlying disease processes or a more severe type of traumatic injury. Many times, bruising or abrasions are found on the exterior chest wall, directly over the left ventricle. Most often, comotio cordis occurs following impact with items like a baseball, softball, or hockey puck. Comotio cordis can also occur following a collision between players, such as in lacrosse, or in a contact sport like karate.

Statistically, most patients who sustain a comotio cordis event are young (95% male, 78% female under age 18), and are involved in an organized sport (62% organized, 38% daily routine and recreational activities). While most people believe a high-energy impact is required to cause comotio cordis, that is not necessarily so. Although some victims had structurally normal hearts with no heart disease, the strikes occurred over the heart at a precise moment, resulting in ventricular fibrillation, cardiac arrest or cardiac sudden death. A strike at the vulnerable time of the heart cycle, between beats, can trigger an abnormal rhythm. Any blow to the chest, regardless of its intensity, velocity or force is capable of producing cardiac arrest. Unfortunately, comotio cordis can be 84% fatal. Early recognition of the arrest, CPR, and early defibrillation seem to offer the best chance of survival.

Cause of Comotio Cordis

What is the cause of this rare and mostly fatal process? The theory is similar to that behind the "pericardial thump". In those cases, the heart is already beating irregularly, and you hope to generate enough electrical energy to reset the heart's electrical conduction by administering a physical blow. A sharp, brisk thump on the sternum (pericardial thump) is capable of terminating ventricular tachycardia or stimulating the heart to beat in cardiac standstill, as the mechanical jot to the chest creates electrical energy equal to about 10 watt-seconds. A sharp and quick manual blow, striking the middle of the sternum with the fleshy art of a clenched fist (hypothernar eminence) from a recommended height of about 8-12 inches can generate about 10 joules. It is important to note that precordial thump should not be overly forceful, since the idea is to produce an electrical impulse causing depolarization of the myocardium, not to manually compress the chest or heart. Although not currently in the ACLS v-fib algorithym, in a monitored and witnessed pulseless arrest, with no defibrillator immediately available, the American Heart Association had considered the precordial thump a Class IIb intervention – acceptable, possibly helpful. In the past, the AHA has stated, "a forceful precordial thump can convert patients out of VF/VT and into a perfusing cardiac function." In order for the precordial thump to work, it must occur very shortly after the onset of ventricular fibrillation. It has been shown that the myocardium needs to be well oxygenated and perfused, as it would be in a healthy young athlete. It is interesting to note that the AHA offered the following precautionary warning: "However, this thump can also convert patients from coordinated cardiac activity into VF/VT or asystole." That is essentially what happens during a strike, causing Comotio cordis.

The basic principle of Comotio cordis is that there is some impact directly over the heart. Mechanical energy is converted into electrical energy, the heart's normal functioning is disrupted and the heart beats irregularly. A rare set of circumstances must coincide to cause Comotio cordis. The impact must occur over the heart itself, and it must fall within milliseconds of a critical period of the heart's electrical conduction cycle. To see how this occurs let's look at the cardiac cycle and its electrophysiology.

continued on page 8

(Editor's Note: The article, at this point, goes into the cardiac function with technical information. For a full transcript, see EMS Magazine.)

Surviving a Comotio Cordis Event

The 16% of patients who survive a comotio cordis event have three things in common:

1. Early recognition of the arrest
2. Treatment with CPR and early defibrillation
3. Since it might not be feasible to have local EMS agencies stand by at every organized game, educating coaches and parents about this potentially fatal injury is a must.

Coaches and other responsible individuals need to be trained in CPR, and emergency equipment needs to be available at organized sporting events

The increase in numbers of community-based automated external defibrillators (AED's) is an important development in the ability to resolve ventricular fibrillation. In the absence of available defibrillation, early institution of CPR, along with rapid activation of the local ACLS EMS system, is the next best solution. Survival rates rapidly drop to zero when interventions are delayed. Chest strike protection is available, although not widely used. Some cases of Comotio cordis have occurred to those who routinely wear protective gear, like baseball catchers. Softer "safety" baseballs are available and reduce the risk; however, there still remains a chance of a Comotio cordis event occurring, even with their use. Protective gear is beneficial, but also might add a false sense of security.

When EMS responds to an athlete-down call, the possibility of a Comotio cordis event should always be considered, even though it's rare. A Comotio cordis event is one time when a pediatric arrest is not due to airway compromise. Maintaining certification and familiarity with both current ACLS (Advanced Cardiac Life Support) and PALS (Pediatric Advanced Life Support) protocols is of great importance. The odds are you might never see a Comotio cordis event in your career; however, knowledge of the processes involved, as well as being properly prepared for one, are signs of a true professional.

Umpire Guidelines

North Issaquah, Washington, Little League

Before the Game — Meet at home plate

- Introduce plate and base umpires, managers/coaches
- Receive official lineup cards from each team
- Discuss any local playing rules (time limit, playing boundaries, etc.)
- Discuss the strike zone
- Discuss unsportsmanlike conduct by the players
- Discuss the innings pitched by a pitcher rule
- Clarify calling the game due to weather or darkness
- Inspect playing field for unsafe conditions
- Discuss legal pitching motions or balks, if needed
- Discuss no head-first slides, no on-deck circle rules
- Get two game balls from home team
- Be sure players are not wearing any jewelry
- Be sure players are in uniform (shirts in, hats on)
- Inspect equipment for damage and to meet regulations
- Ensure that games start promptly

During the Game — Umpires and Coaches

- Encourage coaches to help speed play by having catchers and players on the bench prepared and ready to take the field with two outs
- Make sure catchers are wearing the proper safety equipment
- Continually monitor the field for safety and playability
- Pitchers warming up in foul territory must have a spotter and catcher with full equipment
- Keep game moving — one minute or eight pitches to warm up the pitcher between innings or in case of mid-inning replacement
- Make calls loud and clear, signalling each properly
- Umpires should be in position to make the call
- No protesting of any judgment calls by the umpire
- Managers are responsible for keeping their fans and players on their best behavior
- Encourage everyone to think "Safety First!"

Copy and provide to umpires for reference.

First Aid Kits: What goes in them?

Requirement 12

"Hello, I need a list of what to put in a team first aid kit as well as the big first aid kits kept at the fields. I have a sponsor willing to fill this need. I just need to give them a list of what we need and how many."

Thanks,
Marc Paladino
(via email)

A team's first aid kit should contain ice in bags; these will be used almost anytime you have an injury to help reduce the pain and potential swelling. If using chemical cold packs, be cautious using around the face in case of leaks. Also, bandages, both large and small, gauze, some kind of dressing material like an Ace wrap or elastic wrap to hold gauze in place, or athletic tape. You should also provide water or a cleanser (antiseptic wipes, etc.) to clean abrasions or cuts. Check local expectations for first aid kits, as some states do not allow these cleansers other than at home or by health care professionals.

Also, don't forget latex or rubber gloves and some kind of small bag to properly dispose of blood and blood-soiled items like wipes or towelettes; blood-borne pathogens should be an important part of your safety training, so people do not put their health and future safety at risk dealing with unknown risks.

Finally, each team should have some kind of emergency telephone (mobile or land-line) to call an ambulance as well as a map or written directions to the area medical facilities anyone evacuated by medical professionals would be taken to. In an emergency, people need all the help they can get. Check the November/December 2003 ASAP News for some examples of that kind of information.

NOTE: Individual leagues decide what they need in a first aid kit. These give a good idea of fully-stocked kits. Items any kit should contain: A good supply of ice, drinking water, and personal items or medications; emergency phone numbers; coins for pay phones; and directions and/or a map to/from emergency medical facilities.

ALSO: Keep a list of original supplies in your first aid kit, so it can be stocked and replenished! If managers or coaches use any first aid supplies, replace them before the next time the team meets.

Here are three good examples of a well-stocked first aid kit:

LLB's Emergency Management and Training Program

Little League's EMTP manual recommends your first aid kit include:

Ice bags
- Plastic bags of crushed ice

Elastic bandages
- 3, 4 and 6 inch widths

Sterile dressings
- 3 by 3 inch individual gauze
- 2 to 3, 5 by 9 inch pads
- Telfa or non-stick dressings
- Eye patches

Adhesive bandages
- 3/4, 1 and 2 inch widths

Bandages
- Triangular shape and in rolls

Adhesive tape
- 1/2, 1 and 1 1/2 inch widths

Eye shields

Small flashlight

Scissors

Antiseptic soap

Splints
- Inflatable, cardboard or wooden, for arm and leg (large enough for your largest player)

Petroleum jelly

Safety pins

First aid manual

Towels

Blanket

Small pocket notebooks and pencils
Water for drinking and plenty of paper cups. (Water and paper cups can also do double duty in some first aid applications.)

Fyrst USA Sport Medical Kits

A new first aid kit, available both in a team size and a league size, is offered by Fyrst USA. It was developed specifically for sports injuries. A unique feature: resupplies can be ordered by phone and to you in 5-7 days. Call 800/782-1355 or go to www.fyrstusa.com to order.

1 Reusable ice bag: 9 inches
4 Instant cold packs: 6 by 10 inches
1 Blister Kit
20 Bandages: 1- by 3-inches
6 Large bandages: 2 by 4 1/2 inches
1 Elastic wrap
1 Scissors
20 Antimicrobial skin wipes
10 Blood-off cloth towelettes
20 Latex gloves
1 Antiseptic hand cleaner: 4 ounces
2 Rolls of athletic tape
1 Roll of pre-wrap
3 Sport wound care kits
FYRST USA now carries the SAVE-A-TOOTH Preservation System (with ADA Seal of Acceptance)

Little League First Aid Kit

The first aid kit produced by Johnson & Johnson, is available through the equipment and supplies catalog.

Bandages — sheer and flexible
Non-stick pads — assorted sizes
Soft-Gauze bandages
Oval eye pads
Triangular bandage
Hypo-allergenic first aid tape in dispenser
2-inch elastic bandage
Antiseptic wipes
First aid cream
Instant cold pack
Tylenol® extra-strength caplets
Scissors
Tweezers
First aid guide
Contents card
Disposable gloves

You've Got Questions

We've Got Answers

"I searched the (Little League web) site but could not locate the cutoff date for boys Little League? When does the child have to be 12 years by?"

John Yesensky
Email Question

All league ages are determined by the child's age prior to Aug. 1 of the year in question. So practically, that means whatever age the child is as of July 31, 2004, would be their league age this year. Usually this is used as a cutoff, rather than a "by" date, since turning 13 before Aug. 1 means a child must advance to the Junior Division this year, while both an 11-or 12-year-old would be eligible for the Little League (Majors) Division.

"Can a child that is (a league age) 7-year-old be held back to play in Tee-Ball? If the child has a slow development condition and the parent presents a doctor's letter verifying the child's condition can the child be held back to play with the 5-and 6-year-olds in Tee-Ball?"

America Samaniego
Email Question

Yes, according to Little League Rules, Tee-Ball can be for children 5 through age 8, based on ability. It is up to the local league to determine their specific age guidelines for players. While many leagues use a lower age for Tee-Ball (5-6 years) to group players closer by age, those that use a try-out system to determine the playing ability of children may elect to hold the less-developed players back until they reach a level where they are on a par with the children of the Minor League division (typically ages 7-12, again based on ability), with the best players of this group moving into the Major League/Little League division at between 9 and 11 years of age until they are 12).

Your league has a lot of discretion to do what is best for the individual players. It is up to the league's Player Agent to review a player's ability during try-outs and determine if they should be in a different division than the one their age would naturally place them. Hopefully that helps you find a solution that works best for the player involved in this situation.

"I am requesting some more information on the ASAP program. I am in the process of taking over the safety officer position in my town and could use some updated paperwork (Program kit, ASAP news/newsletters, registration forms etc.). My town has a new league president and he and I are committed to make our league and our parks the best they can be for our children and all the children in this league."

Jeffrey T. Mitchell
Acra, NY

The Safety Officer position is an important one, responsible for helping raise awareness of potential safety risks to your league on an on-going basis. The Safety Officer is also the key league resource in tracking and reporting to Little League any injuries that occur to players, volunteers or spectators at your Little League events. A valuable resource for any Safety Officer is the 2004 Safety Officer Manual and League Resources CD, which contains all the information you need to put together a (or improve on your existing) league safety plan. If you have not received your copy, please call the ASAP Hotline at 800-811-7443 and leave your name, league name and mailing address and we will mail one out free of charge to you.

"Is it a requirement for each coach to have a first aid kit in his equipment bag?"

Kevin Hurst

Yes, for a league to have a qualified safety program, they must supply each team with a first aid kit that would be carried to all games and practices. It is not a Little League rule that teams carry first aid kits, just a requirement by ASAP for leagues to qualify. Local leagues are encouraged to adopt a local rule that requires teams to carry first aid kits as part of their safety plan.

"Are portable mounds allowed for Little League Majors and Minors?"

Pam Olson
Email Question

Portable mounds are allowed in Little League play. An example of a portable mound may be found in the 2004 Supplies and Equipment Catalog sent with your league's rule books and league information when you chartered this year.

"We are in the process of deciding whether or not we should use Brick dust or Clay (dust) for our infield. My first thought is that Clay would be the better choice - however, I have no facts or knowledge of either material. Could you please provide your recommendation or where I may get an answer?"

John Petuoglu
Safety Officer
Fillmore Little League

Some people like to use brick dust because it drains better than clay, but it is a coarser material and may exacerbate sliding injuries like cuts

You've Got Questions

We've Got Answers

and abrasions. We would recommend looking at a softer mix of materials that might not use the abrasive brick dust, such as a clay mix. Several vendors offer specific compounds that are intended to drain and play well. We would direct you to a turf management program in your local college or university for additional recommendations on infield material in your area.

"First, thank you for a wonderful Little League web site and your concern for safety. It's most informative."

"I'm trying to find if there is a policy or guideline regarding the use of 'snow fences' as outfield fences or so called 'home run fences?' It seems to me snow fences are for snow, not for baseball. I find then dangerous, but unfortunately find them being used — not just in baseball but on sidelines of other sport fields.

"I'm also trying to buy a Little League Rulebook, but my computer won't let me get into the store section of the web site? I did sign up for your newsletter."

Dick Borkowski
Email Question

Little League does not set specifications for fencing, but the fence use should conform to local codes and be used appropriately. Some fencing is better than no protection, to keep kids from wandering onto a playing field and possibly being injured. Is it ideal? No. Better than nothing? Yes. Several vendors offer portable and temporary fencing that could be purchased for this use and be safer for the kids, if permanent fencing isn't a possibility. In short, as long as it can be used according to local code, it should be used as a short-term solution. Little League Rule Books and Operating Manuals are available only to league and district officials. If you are a league official, you need to enter your league access code to purchase these items. If you are not a league official, contact your league to request a Rule Book.

"Our Little League is considering purchasing the six video set of 'Baseball Skills and Drills' advertised in the 2004 Little League Collection brochure.

"We intend to use the videos to fulfill our fundamentals training for coaches and managers by arranging to present the videos at a designated place and time for all of our managers. The videos would also be available for checkout throughout the year to reinforce fundamentals training in all phases of the game.

"Before purchasing the set, I wanted to be sure that this approach would be acceptable to fulfill the 'Fundamentals Training' portion required under Item 5 of the Registration Form. We have had some difficulty in obtaining and scheduling qualified instructors and winter facilities to conduct this training in the past. I feel we can gain better flexibility in scheduling our sessions and have a long-term resource if we use the videos.

"Please advise if use of the videos will fulfill our Fundamentals Training requirement."

Thomas C. Clements
Safety Officer
M.O.T. Little League

Having someone view videos is not the intent of the training, whether individually or as a group. While these tapes would be an excellent supplement to a speaker on fundamentals, they are not approved as a substitute to an actual person giving fundamentals training and answering resulting questions, and your plan would not meet the minimum requirements. The intent is for a veteran coach, whether from your league or a nearby high school, college or university, to come in and explain the basics of proper techniques. This allows the league volunteers to ask any questions, see the techniques from any angle, and get important feedback about maintaining a safe and healthy team.

"Is there any problem with him wearing a batting helmet on the field while playing defense? I know that in MLB, John Olerud wears a batting helmet while playing first base. I didn't see anything in the rules that prohibits a Little League player from doing the same thing."

Fred Gatto
Safety Officer
Dover, Del. Little League

The rules state all players shall wear the same uniform, but if there is a medical need for a player to be protected by a helmet in order to play, the league certainly can make a reasonable accommodation to allow wearing a helmet, and probably one with a face guard. Have the doctor write a prescription for the helmet to protect the player, and any further requirements so the league understands exactly what is required (a face guard? protective goggles?) and can meet the expectation for a safe environment for the player. If a league wishes to make any modifications to any official rule or regulation, it must be submitted through your Regional Office, and approved by the Charter Committee in Williamsport.

Have a question or tip to share?
Call the ASAP Hotline: **800-811-7443**
or email: **asap@musco.com**

What's Inside

Tips on E. Coli Bacteria Safety

Ground beef is the most common source of the E. coli bacteria, but not the only one. Fruits, vegetables and drinking water also can harbor the deadly pathogen. The Centers for Disease Control and Prevention offer these tips for preventing E. coli infections:

- Cook all ground beef and hamburger thoroughly. Ground beef can turn brown before the bacteria are killed, so it should be heated until a thermometer inserted into several parts of the patty, including the thickest section, reads at least 155 degrees.
- If you are served an undercooked hamburger or other ground beef product in a restaurant, send it back for further cooking.
- To avoid spreading the bacteria in the concession stand, keep raw meat separate from ready-to-eat foods. Wash hands, counters, and utensils with hot soapy water after they touch raw meat. Never place cooked hamburgers or ground beef on the unwashed plate that held raw patties. Wash meat thermometers in between tests of patties that require further cooking.
- Wash fruits and vegetables thoroughly, especially those that will not be cooked. Children under 5 and people with depressed immune systems should avoid eating alfalfa sprouts.
- Drink only pasteurized milk, juice, or cider.
- Drink municipal water that has been treated with chlorine or other effective disinfectants and avoid swallowing lake or pool water while swimming.

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