ARTICLE 43

SPORTS MEDICINE

43.1 DRUGS, ALCOHOL, TOBACCO

43.1.1 AIA POSITION STATEMENT – SUPPLEMENTS, DRUGS AND PERFORMANCE ENHANCING SUBSTANCES

The Arizona Interscholastic Association (AIA) views sports, and the participation of student-athletes in sport, as an activity that enhances the student-athlete's well-being by providing an environment and stimulus that promotes growth and development along a healthy and ethically based path.

- It is the position of the AIA that a balanced diet, providing sufficient calories, is optimal for meeting the nutritional needs of the growing student-athlete.
- It is the position of the AIA that nutritional supplements are rarely, if ever, needed to replace a healthy diet.
- Nutritional supplement use for specific medical conditions may be given individual consideration.
- The AIA is strongly opposed to "doping", defined as those substances and procedures listed on the World Anti-Doping Agency's Prohibited List (www.wada-ama.org).
- It is the position of the AIA that there is no place for the use of recreational drugs, alcohol or tobacco (e-cigarettes) in the lifestyle of the student-athlete. The legal consequences for the use of these products by a student-athlete are supported by the AIA.

In pursuit of Victory with Honor, the AIA promotes the use of exercise and sport as a mechanism to establish current fitness and long-term healthy lifestyle behaviors. It is the position of the AIA that the student-athlete, who consumes a balanced diet practice sport frequently and consistently, and perseveres in the face of challenges, can meet these goals.

43.1.2 At least annually, each member school shall communicate to its students participating in interscholastic activities the AIA Position Statement on the use of supplement, drugs and performance enhancing substances. (See Form 14.13)

43.1.3 Any coach or competitor using tobacco, alcoholic beverages or misusing drugs while participating in interscholastic competition shall be disqualified from the contest or tournament.

43.2 OPIOID EDUCATION - All student athletes shall complete the Opioid online education course prior to participation in practice or competition. The Opioid online education course must be completed by a student-athlete only once.

43.3 HAZING EDUCATION – All student athletes shall complete the Hazing online education course prior to participating in practice or competition. The Hazing online education course must be completed by a student-athlete only once.

43.4 CONCUSSION EDUCATION – All student athletes shall complete the Brainbook online education course prior to participation in practice or competition. The Brainbook online education course must be completed by a student-athlete only once.

43.5 CONCUSSION POLICY

43.5.1 Education

43.5.1.1 All AIA Participating schools must have a concussion policy on file: The policy must address the following:

- Concussion Education
- Removal from Play
- Return to Play
- Return to Academics

43.5.1.2 Parents and athletes must sign a form acknowledging education regarding concussion.

43.5.2 Mechanics and Criteria for Removal from Play

43.5.2.1 An athlete, coach, licensed athletic trainer, team physician, official or parent can remove an athlete from play.

43.5.2.2 Only an appropriate health care professional can refute the diagnosis of a concussion.

43.5.3 Return to Play Criteria

- No athlete should return to play (RTP) or practice on the same day of a concussion.
- Any athlete suspected of having a concussion should be evaluated by an appropriate health-care professional that day.
- Any athlete with a concussion should be medically cleared by an appropriate health-care professional prior to resuming participation in any practice or competition.
- After medical clearance, return to play shall follow a step-wise protocol with provisions for delayed return to play based as directed by an appropriate health-care professional.
- Return to play should only occur after an athlete has returned to full school attendance without academic accommodations.

43.5.4 Appropriate Health-Care Professionals for Return to Play

An appropriate health-care professional is defined as the following:

- Licensed Athletic Trainer
- Physician (MD/DO)
- Licensed Nurse Practitioner
- Physician's Assistant

43.5.5 Return to Academics

- Cognitive rest, including reduced screen time, may be recommended for the first 24-48 hours.
- Student-athletes can engage in sub-symptom cognitive activities as tolerated.
- Cognitive exertions should be stopped if concussion symptoms exacerbation is more than mild and brief and may be resumed once symptoms have returned to their prior level. Mild symptom exacerbation is typically brief and does not delay recovery.
- Schools should have policies to facilitate academic support, especially those that address factors that may prolong return to the classroom (e.g. High symptom burden, social determinants of health).
- Not all student-athletes will need academic support or a return to learn strategy.
- While return to learn and return to sport strategies can occur in parallel, student athletes should complete return to learn before unrestricted return to sport.
- Returning an athlete to the classroom following a concussion should follow a return to learn progression.

43.5.6 Other

43.5.6.1 At the beginning of a game, the coach must certify to the official that the equipment is in compliance with safety regulations and properly fitted.

43.5.6.2 If a helmet comes off or becomes dislodged during play, must remain out for one play or call a time out to have the equipment reassessed.

43.6 HEAT ACCLIMATIZATION & EXERTIONAL HEAT ILLNESS MANAGEMENT POLICY

43.6.1 **Definitions**

Exertional heat illness includes the following conditions, ordered from the least to the most dangerous:

a) **Exercise associated muscle cramps**: an acute, painful, involuntary muscle contraction usually occurring during or after intense exercise, often in the heat, lasting approximately 1-3 minutes.
b) **Heat syncope**: also known as orthostatic dizziness, it refers to a fainting episode that can occur in high environmental temperatures, usually during the initial days of heat exposure.
c) **Exercise (heat) exhaustion**: the inability to continue exercise due to cardiovascular insufficiency and energy depletion that may or may not be associated with physical collapse.
d) **Exertional heat stroke**: a severe condition characterized by core body temperature >40°C (105°F), central nervous system (CNS) dysfunction, and multiple organ system failure induced by strenuous exercise, often occurring in the hot environments.

43.6.2 **Prevention**

It is the position of the AIA that prevention is the best way to avoid exertional heat stroke.

1. Education

Athletes and coaches should be educated on how to properly hydrate and minimize risk of exertional heat illness. This may be done through team lectures, educational handouts, guest speakers, or any other means created by the institution and Athletic Trainer.

Athletes and coaches should receive education on how to monitor hydration and rehydration needs by obtaining a weight pre and post activity, and how to recognize and treat someone suspected of exertional heat stroke. Athletes should understand the importance of being well hydrated prior to starting any activity.

Athletic Trainer, coaches, administrators, athletes, and should be aware of individuals with pre-existing conditions that increase the risk of heat illnesses. This may be acknowledged on per-participation exams or brought to the attention of the individual.

Examples of conditions that would increase the risk of heat illness include but are not limited to: a history of heat illness, sickle cell trait/disease, those with known recent illness, individuals who are obese, individuals taking medications and those known to have recently relocated from a more moderate climate.

School personnel should be educated on the signs and symptoms of heat illness and monitor student athletes for any signs of a heat illness throughout practice. These signs and symptoms include (but are not limited to) the table below.

Rectal temperature greater than 105 (40°C) at time of incident.	Rapid pulse, low blood pressure, quick breathing
Headache	Dehydration, dry mouth, thirst
Confusion or just look "out of it"	Decreasing performance or weakness
Disorientation or dizziness	Profuse sweating
Altered consciousness, coma	Collapse, staggering or sluggish feeling
Nausea or vomiting	Muscle cramps, loss of muscle, function/balance, inability to walk
Diarrhea	Irrational behavior, irritability, emotional instability

2. Hydration Strategies

Each institution should develop an appropriate process for hydration distribution. This should include who is responsible for preparing, distributing, refilling, and cleaning hydration means for both practices and games. Different types of fluids may be available depending on institution resources. Fluids should help to offset sweat loss, maintain hydration, and avoid overdrinking.

3. Equipment Considerations

- Wear loose-fitting, light colored and absorbent/moister wicking clothing
- During hot or humid conditions minimize the amount of equipment and clothing worn. (Football: reduce the amount of equipment worn, i.e. helmet and/or shoulder pads)

4. Practice Structure and Time Considerations

- Direct sunlight and high temperatures are most common between the hours of 10 am and 5 pm. During extreme heat, it is best to avoid activities during this timeframe. Always follow guidelines for environmental monitoring for activity modifications.
- As temperatures rise the athlete's ability to counteract a potential rise in body temperature is reduced increasing their risk of heat illness. In order to offset this risk, practice should be shortened when indicated by current environmental conditions.

5. Heat Acclimatization Protocol:

- **This applies to all football and outdoor fall sports teams**
- **A team may not choose to conduct their acclimatization training in a less sever climate.**
- Other sports should follow a heat acclimatization protocol if practicing when the **average WBGTs are in the orange-red zones.**

Day 1-5 of Formal Practice

Criteria	Restrictions
Total Practices per Day	1 practice per day
Inclement Weather/Heat Restrictions	- If a scheduled practice is cancelled due to inclement weather the corresponding acclimatization stage must be completed prior to progressing to the next stage.
Total Practice Time Allotted	Should NOT exceed 3 hours in any single day
Walk-Through Regulations	- Maximum of 1 hour. - Must have a 3-hour recovery period between practice and walk-through (or vice versa).
Walk-Through Definition	- Individuals should not exert themselves to the point in which they cannot hold a conversation - No contact with other individuals, dummies, sleds, or shields
Equipment & Contact Restrictions	**Day 1-3 All sports:** Helmet only. Shields and dummies only as a *non-contact* teaching tool. **Day 4-6 Football:** Helmet & Shoulder Pads only. Contact with blocking sleds and tackling dummies may begin. **Days 7-14 Football:** All protective equipment may be worn. Full contact can begin.

Days 6-14 of Formal Practice

Criteria	Restrictions
Total Practices per Day	Double-practice days must be followed by a single-practice day
Single Practice Days	1 walk-through is allowed, separated from the practice by at least 3 hours of continuous rest.
Double Practice Days	- Double practice day must be separated by a rest day. - Neither practice should exceed 3 hours. - Maximum total practice time: 5 hours - Each practice must be separated by a minimum of 3 continuous hours of rest in a cool environment - Warm-up, stretching, cool-down, walkthrough, conditioning and weight-room activities are included in practice time.

6. Environment Monitoring and Activity Modification

Recommended Equipment:

- Use a WBGT device equivalent to **Kestrel 5400**

Measurement Guidelines:

- WBGT will be obtained on the same playing surface as the practice/event site
- Anytime it is warm outside, specifically anytime it is over 80° F with high humidity
- All environmental monitoring & recommendations should be documented
- May all be utilized for indoor facilities, when not temperature controlled

Monitory Frequency:

- Take WBGT every 30 minutes or as needed due to significant change in weather

Activity Modification:

- Based on WBGT ranges with Arizona being identified as Region 3
  - *See resource: https://ksi.uconn.edu/wp-content/uploads/sites/1222/2018/08/RegionalWBGT_2015_AppliedGeography.pdf*
- Practice modifications are flexible and based on the current environmental conditions: stricter under more oppressive temperatures and relaxed as conditions improve
- Activity modifications based on WBGT readings apply to all sports and training activities. With the exception of in-water activities for aquatic sports (swim/dive). **Aquatic sports** coaches should consider water temperature and availability of shade, ice and water when deciding appropriate mitigation strategies and/or activity modifications. Any dry land training will following the outlined guidelines as directed for all sports.

WBGT	Activity Guidelines
< 82.0	Activity: Normal Rest Breaks: minimum of 3-minute break every 20 minutes of activity
82.1 - 86.9	Activity: use discretion for intense or prolonged exercise Rest Breaks: minimum of 4-minute break, every 20 minutes
87.0 - 90.0	Activity: maximum practice time is 2 hours Rest Breaks: minimum of 4-minute break every 15 minutes Equipment Restrictions: Helmet, shoulder pads, and shorts during practice. If the WBGT reaches this zone after practice has started: players may continue in pants
90.1 - 91.9	Activity: Maximum practice time is 1 hour. No conditioning activities. Rest Breaks: minimum of 5-minute break every 15 minutes Equipment Restrictions: NO protective equipment to be worn Off campus sports: a designated adult is within line of sight to all athletes to monitor signs of heat illness and activate an emergency action plan if needed.
≥ 92.0	No outdoor workouts. Delay practice until a cooler WBGT is reached.

43.6.3 **Exertional Heat Stroke Treatment: This is a medical emergency.**

1. Recognition
   - Any athlete with signs of central nervous system dysfunction during exercise in the heat should be suspected to be suffering from EHS. Please see table above to review additional signs and symptoms of exertional heat stroke.
   - Immediately active EMS and site-specific exertional heat stroke protocol
   - It is important to emphasize that during and following intense exercise in the heat, temporal, aural, oral, skin, axillary and tympanic temperature are not valid and should never be utilized in diagnosis of a potential exertional heat stroke. Rectal temperature is the only valid measuring tool sensitive enough to accurately diagnose exertional heat stroke.

2. Cooling
   - The patient must be cooled immediately.
   - If accessible, move to a cooler environment
   - Remove excess clothing and equipment
   - Utilize one or more of the acceptable immersive cooling methods:
     - Cold-water immersion (35-59°F) tub up to the neck if possible
     - Tarp Assisted Cooling Oscillation (TACO)

   If immersive techniques are unavailable utilize other cooling means such as Ice bags/towels on the groin, neck, and axilla until EMS arrives and can immediately transport to a higher level of care.
   See Resources: PowerPoint Presentation (nata.org) or untitled (nata.org)
   - Vital signs should be monitored every 5 minutes throughout cooling process

   Cool First, Transport Second
   - When a patient is diagnosed with EHS, the principle of Cool First, Transport Second should be used when immersive cooling is available.
   - Patient should be kept in immersive cooling until reaching a core temperature of **~102°F** measured via rectal thermometry

43.6.4 **Exertional Heat Stroke Return to Play**

- Refrain from exercise for at least 7 days following the acute event
- Prior to beginning a return to exercise, anyone suspected of suffering from a heat stroke must receive clearance by a physician or advanced practice provided (MD, Do, NP, PA-C)
- Upon clearance by a provided:
  - Begin exercise in a cool environment and gradually increase the duration, intensity, and heat exposure over 2 weeks to acclimatize and demonstrate heat tolerance.
- Refer for follow up with provider if unable to complete a full return after 2 weeks of acclimatization

43.7 MEDICAL INTERVENTION PROCEDURE

43.7.1 Medical interventions which increase the risk of disease exacerbation or additional injury are never appropriate on the day of competition, or on any other day, for a high school student-athlete. There are three steps of decision making for the basis of the Return to Play decision. These include evaluation of health risks, participation risks, and any factors in decision modification. If a disease process or injury is not adequately controlled by the day of competition to allow safe clearance for play with full function, then invasive medical procedures on the day of competition, performed with the sole purpose of enabling the student-athlete to participate, are philosophically inappropriate and shall not be performed on site. These prohibitive procedures are to include IV's, joint injections, and prescription strength medications not prescribed appropriately to the student athlete.

43.8 EMERGENCY ACTION PLANS

43.8.1 An Emergency Action Plan (EAP) for each practice and competition site, used by the school, shall be completed annually by each member school. The EAP must be kept on file at the school and shared with the appropriate coaches and staff. The emergency action plan should be comprehensive and practical, yet flexible enough to adapt to any emergency situation.

43.8.2 The Emergency Action Plan should contain the following information and/or components:

- Emergency plans must be written documents and should be developed in concert with the member schools' certified athletic trainer(s).
- Emergency plans must be written documents and should be distributed to team and attending physicians, athletic training students, institutional and organizational safety personnel, institutional and organizational administrators, and coaches.
- The emergency plan should be developed in consultation with local emergency medical services personnel.

(Section 43.7 cont'd. on next page)

- An emergency plan for athletics identifies the personnel involved in carrying out the emergency plan and outlines the qualifications of those executing the plan.
- Sports medicine professionals, officials, and coaches should be trained in automatic external defibrillation, cardiopulmonary resuscitation, first aid, and prevention of disease transmission.
- The emergency plan should specify the equipment needed to carry out the tasks required in the event of an emergency. In addition, the emergency plan should outline the location of the emergency equipment. Further, the equipment available should be appropriate to the level of training of the personnel involved.
- Establishment of a clear mechanism for communication to appropriate emergency care service providers and identification of the mode of transportation for the injured participant are critical elements of an emergency plan.
- The emergency plan should be specific to the activity venue. That is, each activity site should have a defined emergency plan that is derived from the overall institutional or organizational policies on emergency planning.
- Emergency plans should incorporate the emergency care facilities to which the injured individual will be taken. Emergency receiving facilities should be notified in advance of scheduled events and contests. Personnel from the emergency receiving facilities should be included in the development of the emergency plan for the institution or organization.
- The emergency plan specifies the necessary documentation supporting the implementation and evaluation of the emergency plan. This documentation should identify responsibility for documenting actions taken during the emergency, evaluation of the emergency response, and institutional personnel training.
- The emergency plan should be reviewed and rehearsed annually, although more frequent review and rehearsal may be necessary. The results of these reviews and rehearsals should be documented and should indicate whether the emergency plan was modified, with further documentation reflecting how the plan was changed.
- All personnel involved with the organization and sponsorship of athletic activities share a professional responsibility to provide for the emergency care of an injured person, including the development, implementation and regular, periodic evaluation of an EAP.

43.9 STUDENT INSURANCE

It is recommended that each student athlete have on file with the principal or his/her designee proof of insurance coverage or a waiver prior to practice.

43.10 POST SEASON EVENT PROTOCOL

43.10.1 Applies for the following AIA Post Season Events:

- Football
- Volleyball
- Soccer
- Basketball
- Wrestling
- Baseball
- Softball
- Spiritline

43.10.2 An Emergency Action Plan (EAP) must be filed with AIA in order to host a post season tournament.

43.10.3 Qualified Medical Profession (QMP)/EMT Coverage.

43.10.3.1 All ATC/QMP/EMT services at AIA Post Season Events will be paid or reimbursed by the AIA. (Note: “Region” events are not AIA events – ATC/QMP/EMT is not paid by AIA)

43.10.4 AIA State Tournaments at High Seed Sites:

43.10.4.1 Member schools must engage a qualified medical professional (QMP) or Emergency Medical Technician (EMT). One of the following three protocol options must be followed or payment may not be issued:

43.10.4.2 If there is no QMP or EMT at the game, the game shall not be played.

43.10.4.2.1 QMP as defined by Arizona Revised Statute §15-341:

- ATC – Certified Athletic Trainer
- MD – Medical Doctor
- DO – Doctor of Osteopathic Medicine
- NP – Licensed Nurse Practitioner
- PA – Licensed Physician’s Assistant

(Section 43.9 cont’d. on next page)

43.10.4.2.2 If a school does not have a QMP or EMT and the opposing school does, in order for the game to proceed, the QMP or EMT agrees to cover the opposing school as well as their own school.

43.10.4.3 If ONLY an EMT is at the game, any player removed due to suspected head injury or concussion will not be allowed to enter or re-enter the game based on an EMT evaluation. Return to play can only be based on evaluation by a QMP.

43.10.5 AIA State Tournaments at Neutral Sites:

- AIA Staff will secure QMPs that will be contracted through the AIA or a third-party vendor.
- If the QMP is a Certified Athletic Trainer, **the ATC must provide the AIA with a certificate of professional liability insurance** and be familiar with the AIA/ATC protocol.

43.11 AIA POLICY AND PROCEDURE RELATED TO DISABILITY DISCRIMINATION (SECTION 504 AND AMERICANS WITH DISABILITYES ACT)

It is the policy of the AIA not to discriminate based on disability in admission to, access to, or operation of its programs, services, and activities.

Persons with a disability may request reasonable accommodation(s) or modification(s) by making a written request to the AIA Compliance Officer (Compliance Officer) named below. Requests should be made as early as possible to allow adequate time to consider and arrange for any accommodation or modification. An individualized inquiry will be made to determine whether a specific accommodation or modification for a particular person's disability is reasonable under the circumstances as well as necessary for that person and does not fundamentally alter the nature of the service, program, or activity. The Compliance Officer will consult with and obtain input from the requestor's school/district regarding the reasonableness of the accommodation or modification request. A written response to the request will be provided by the Compliance Officer within ten (10) business days, with a copy of that written response provided to the relevant school/district. Questions, concerns, complaints, or requests for additional information should be directed to the Compliance Officer.

The designated Compliance Officer, and contact information, is:

Dr. Jim Dean, Executive Director
7007 N. 18th St.
Phoenix, AZ 85020
(602-385-3811)
Email: jdean@aiaonline.org

Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under the following procedure. It is against the law for AIA to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

Procedure:

Grievances must be submitted to the Compliance Officer within thirty (30) days from the date the person filing the grievance becomes aware of the alleged discriminatory action;

A grievance must be in writing, containing the name and address of the person filing it, and must state with specificity the problem or action alleged to be discriminatory and the remedy or relief sought;

The Compliance Officer shall conduct an investigation of the grievance. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the grievance;

The Compliance Officer will issue a written decision after completion of the investigation, within thirty (30) days from the receipt of the grievance, unless extenuating circumstances require additional time, and in such case the Compliance Officer will communicate with the complainant concerning the need and reasons for an extension. The written decision will be provided to the complainant and relevant member school/district;

The person filing the grievance may appeal the decision of the Compliance Officer by writing Dr. Jim Dean, AIA Executive Director, 7007 N. 18th St, Phoenix, AZ 85020 (email: jdean@aiaonline.org) , within twenty (20) days from the date of the decision of the Compliance Officer. The Executive Director shall issue a written decision in response to the appeal within thirty (30) days from the date of receipt of the appeal. The written decision will be provided to the complainant and relevant member school/district.

The above policy and procedure is posted on AIA's website, aiaonline.org, including the identification of and contact information for the Compliance Officer.