Danville Little League
2019 Safety Manual
For
Managers and Coaches

Play It Safe

League ID Number

405-57-09

Danville Little League
P.O. BOX 1174
Danville, California 94526

DANVILLE LITTLE LEAGUE

Danville Little League is a chartered member of Little League Baseball, headquartered in Williamsport, Pennsylvania. We are in the Western Region, headquartered in San Bernardino, California and part of the local District 57. Our boundaries are predetermined by District 57 and do not follow school boundaries. Danville Little League supports the following:

League Age 5	T-Ball Division
League Age 6	Rookie Ball Division
League Age 7	Farm Division
League Age 8	Single A Division
League Age 9	Single A or AA Division (AA if drafted)
League Age 10	AA or AAA Division (AAA if drafted)
League Age 11	AAA or Majors (Majors, if drafted)
League Age 12	Majors Division (or AAA if waiver submitted)
League Ages 13-18	Intermediate, Junior 80s, Junior 90s, Juniors Gold, Seniors or Srs Premier, Big League

DANVILLE LITTLE LEAGUE MISSION STATEMENT

The mission of Danville Little League is to provide quality baseball experiences to Danville youth in a safe environment that balances integrity, respect, competition, fun and fair play.

SAFETY MANUAL POLICY STATEMENT

This Safety Manual has been established in accordance with Little League Baseball guidelines and consistent with ASAP (A Safety Awareness Program), which was introduced to create awareness, through education and information, of the opportunities to provide a safer environment for kids and all participants of Little League Baseball. All Danville Little League managers and coaches shall have the responsibility to read and understand this Safety Manual. The manager of each team shall be responsible for the safety of the team's players and shall act as the team's safety officer. If the manager leaves the field he/she shall designate a registered coach or parent as his substitute, who shall, while in such capacity also be the substitute team safety officer under this Safety Manual.

DANVILLE LITTLE LEAGUE CODE OF CONDUCT

No Board Member, Manager, Coach, Player or Spectator shall:

- Physically attack, trip, push, shove, strike, or threaten to strike anyone.
- Impose personal verbal or physical abuse upon any official for any real or imaginary belief of a wrong decision or judgment.
- Be guilty of an objectionable demonstration of dissent at an official's decision by throwing of gloves, helmets, hats, bats, balls, or any other forceful unsportsmanlike action.
- Challenge the umpire's authority.
- Use unnecessarily rough tactics in the play of a game against the body of an opposing player.
- Speak or act in a disrespectful, demeaning or unsportsmanlike manner towards any player, official, coach, manager or spectator.
- Use any profane, obscene or vulgar language or gesture(s) in any manner, at any time.
- Appear on the field of play, stands or near the stands, while in an intoxicated state or what reasonably appears to be in such a state.
- Gamble or bet upon any play or outcome of any game.
- Smoke or use tobacco products, or what could be confused with tobacco products by a youth, when in team uniform or while at the ballpark, parking lot or with the players in a League event or capacity.
- Publicly discuss in a derogatory, demeaning or abusive manner any play, decision or personal opinion on any player, official, coach, manager or spectator.
- Willfully, or repeatedly, violate any safety rules including pitch count rules.
- Tamper with or manipulate any League rosters, schedules, draft positions or selections, official scorebooks, rankings, financial records, policies or procedures, or the minutes of any official League meeting.

Any umpire shall have the authority and discretion during a game to penalize the offender for any violation of this Code of Conduct, according to the severity of the infraction, up to and including expulsion from the game.

The Conduct Committee of the Board of Directors will review all infractions of this Code of Conduct. Depending on the Committee's evaluation of the seriousness of the offense, or its frequency, the Board in its sole and absolute discretion may assess additional disciplinary action up to and including expulsion from the League.

Coaches, are your "expectations" reasonable and consistent?

WHAT YOU SHOULD EXPECT FROM YOUR PLAYERS

- to be on time for all practices and games.
- to always do their best whether in the field or on the bench.
- to be cooperative at all times and share team duties.
- to respect not only others, but themselves as well.
- to be positive with teammates at all times.
- to try not to become upset at their own mistakes or those of others.
- to support one another.
- to understand that winning is only important if you can accept losing, as both are important parts of any sport.

WHAT PARENTS AND PLAYERS SHOULD EXPECT FROM YOU

- to be on time for all practices and games.
- to be as fair as possible in giving playing time to all players.
- to do your best to teach the fundamentals of the game.
- to be positive and respect each child as an individual.
- to set reasonable expectations for each child and for the season.
- to teach the players the value of winning and losing.
- to be open to ideas, suggestions or help.
- to never holler at any member of your team, the opposing team or the umpires. Any confrontation will be handled in a respectful, quiet and individual manner.

WHAT YOU SHOULD EXPECT FROM PARENTS AND FAMILY

- to come out and enjoy the game. Cheer to make all players feel important.
- to allow you to coach and run the team.
- to try not to question your leadership. All players will make mistakes and so will you.
- to not holler at the coaches, the players or the umpires. We are all responsible for setting examples for our children. We must be the role models in society today. If we eliminate negative comments, the children will have an opportunity to play without any unnecessary pressures and will learn the value of sportsmanship.
- to not question the coaching strategies or leadership in front of the players or fans, but to discuss any concerns with you in private.

Don't expect the majority of children playing Little League baseball to have strong skills. We hear all our lives that we learn from our mistakes. Let's allow them to make their mistakes, but always be there with positive support to lift their spirits!

Danville Little League Phone Numbers

Main Number……..(925) 277-5340
Field Conditions..……..(925) 314-3484
Danville Emergency.....…….....911
Danville Emergency from Cell.....925-838-6691

League Members

Name	Position	Email
Kevin Salmon*	President	president@danvillelittleleague.net
Marc Silveira*	Conduct Committee	conduct@danvillelittleleague.net
Lew Carpenter*	Vice President	vicepresident@danvillelittleleague.net
Scott Diekman*	Player Agent (Majors)	playeragent-majors@danvillelittleleague.net
Lew Carpenter & Jim Ludwig	Player Agent (Minors)	playeragent-minors@danvillelittleleague.net
Brian Balingit*	Treasurer	treasurer@danvillelittleleague.net
Scott Diekman*	Field Main. Dir. & Sports Alliance Rep.	fields@danvillelittleleague.net
Kathleen DeLaney*	Legal Counsel	legal@danvillelittleleague.net
Cyndee Ragan	League Coordinator	coordinator@danvillelittleleague.net
Cyndee Ragan	League Information Officer	info@danvillelittleleague.net
Cyndee Ragan	Carnival	carnival@danvillelittleleague.net
Lew Carpenter	Tryouts	tryouts@danvilleltttleleague.net
Kathleen DeLaney*	Secretary	secretary@danvillelittleleague.net
Brent Johnson*	Umpire-in-Chief	umps@danvillelittleleague.net
Bud Rogers	Umpire Scheduler	umpscheduler@danvillelittleleague.net
Cody Moxley	Safety Director	safety@danvillelittleleague.net
Tom Burrill	Immediate Past President	pastpresident@danvillelittleleague.net
TBD	T-Ball Ball Director	tball@danvillelittleleague.net
TBD	Rookie Ball Director	rookie@danvillelittleleague.net
TBD	Farm Director	farm@danvillelittleleague.net
Corey Fitzgibbon	A Director	adivision@danvillelittleleague.net
Chris French	AA Director	aadivision@danvillelittleleague.net
Chad Power	AAA Director	aaadivision@danvillelittleleague.net
Ben Mendoza/Tim Seiler	Majors Director	majorsdivision@danvillelittleleague.net
Steven Pugh	Jr/Sr Director	juniorsenior@danvillelittleleague.net
Keith Riley	Challenger Co-Directors	challenger@danvillelittleleague.net
TBD	50/70s Division Director	intermediatedivision@danvillelittleleague.net
Tim Seiler, Aaron Mahler & Marc Silveira	Equipment	equipment@danvillelittleleague.net
Jill Rebiejo	Concession Manager	snackshack@danvillelittleleague.net
Brent Johnson	Post Season	postseason@danvillelittleleague.net
Kathleen DeLaney*	Publicity/Social	publicity@danvillelittleleague.net
Cyndee Ragan	Registration	registration@danvillelittleleague.net
Kathleen Delaney & Jill Rebiejo	Scorekeeping	scorekeeping@danvillelittleleague.net
Bob Hammer & Mark Pleis	Sponsors	sponsors@danvillelittleleague.net
Corey Fitzgibbon & Bill Reeves	Training Co-Directors	training@danvillelittleleague.net
TBD	Volunteer Coordinator	volunteers@danvillelittleleague.net
David Gehrke & John Rau	8s/9s Academy Directors	89Academy@danvillelittleleague.net

DANVILLE LITTLE LEAGUE

INJURY REPORT

Player Injured: _____ **Time of Injury:** _____

Name and phone number of person filling out this form: _____

Date of Injury: _____ **Age:** _____ **Sex: M F**

Player Injured Address: _____

Player Injured Phone #: _____ **Field:** _____

Exact location injured on the playing field: _____

Incident occurred during: Game ( ) Practice ( ) Other ( )

Detail
What was the injured player doing when the incident occurred?
Who else was involved?
What specific parts of the body were injured?

Immediate Action Taken
(Please Check)

No treatment of injury: ( )

First aid administered: ( ) Type of first aid: _____

Taken to a physician: ( ) Persons name escorting injured player: _____

Taken to hospital: ( ) Hospital name: _____

Was a parent / relative / guardian notified: Yes No

If "YES": Name and relationship to injured player: _____

Follow Up
Please explain any follow up action taken by the coach.
(Example: Coach calls injured player at home)

Comments or suggestions on how this injury could be avoided in the future:

Complete and mail within 24 hours of the incident to:
League Safety Director
PO BOX 1174, Danville, CA 94526
(This form is used by DDL for statistics and safety purposes. This is not an insurance form.)

INSURANCE POLICIES

Little League accident insurance covers only those activities approved or sanctioned by Little League Baseball, Incorporated. Danville Little League participants shall not participate as a Little League team in games with other teams of other programs or in tournaments except those authorized by Little League Baseball, Incorporated.

Explanation of Coverage:

The *CNA Little League's insurance policy* is designed to afford protection to all participants at the most economical cost to DLL. It can be used to supplement other insurance carried under a family policy or insurance provided by a parent's employer. If there is no other coverage, CNA Little League insurance - which is purchased by the DLL, not the parent - takes over and provides benefits, after a *$50 deductible* per claim, for all covered injury treatment costs up to the maximum stated benefits. This plan makes it possible to offer exceptional, low-cost protection with assurance to parents that adequate coverage is in force at all times during the season.

The Little League Insurance Policy is designed to supplement the Parent's existing family policy.

How the insurance works:

1. The child's parents must first file a claim under their own insurance policy.
2. Should the family's insurance plan not fully cover the injury treatment, the Little League CNA Policy will help pay the difference, after a *$50 deductible* per claim, except for the Travel Sickness Benefit, up to the maximum stated benefits. This includes any deductibles or exclusions in the family's insurance.
3. If the child is not covered by any family insurance, the Little League policy becomes primary and will provide benefits for all covered injury treatment costs, after a *$50 deductible* per claim, up to the maximum benefits of the policy except for the Travel Sickness Benefit.
4. Treatment of *dental injuries* can extend beyond the normal 52 week period if dental work must be delayed due to physiological changes of a growing child. Benefits will be paid at the time treatment is given, even though it may be some years later. Maximum dollar benefit is $1,500 for eligible dental treatment after the normal fifty-two week period, subject to the $50 deductible per claim. Expenses for deferred dental treatment are only covered if they are incurred on or before the insured's 23rd birthday.

Filing a Claim:

When filing a claim, all medical costs should be fully itemized. If no other insurance is in effect, a letter from the claimant's employer explaining the lack of Group or Employer insurance must accompany a claim form. On *dental claims*, it will be necessary to fill out a Major Medical Form, as well as a Dental Form; then submit them to the insurance company of the claimant, or parent(s)/guardian(s), if claimant is a minor. "Accident damage to whole, sound, normal teeth as a direct result of an accident" must be stated on the form and bills. Forward a copy of the insurance company's response to Little League Headquarters. Include the claimant's name, League ID, and year of the injury on the form. Claims must be filed with the DLL Safety Director. He/she forwards them to Little League Baseball, Incorporated, PO Box 3485, Williamsport, PA, 17701. Claim officers can be contacted at (717) 327-1674 and fax (717) 326-1074.

Contact the DLL Safety Director for more information

STORAGE SHED/BIN PROCEDURES

The following applies to all of the equipment bins and the storage shed used by Danville Little League and applies to anyone who has been issued a key by Danville Little League to use those bins/shed.

- All individuals with keys to the Danville Little League equipment bins (i.e., Managers, Umpires, etc.) are aware of their responsibilities for the orderly and safe storage of rakes, shovels, bases, and other equipment.
- Before you use any machinery located in the bins/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 Danville Little League bins/shed shall be properly marked and labeled as to its contents.
- All chemicals or organic materials (e.g. lime, fertilizer, etc.) stored within these equipment bins/shed will be separated from the areas used to store machinery and gardening equipment (e.g. rakes, shovels, etc.) to minimize the risk of puncturing storage containers.
- Any witnessed "loose" chemicals or organic materials within these bins/shed should be cleaned up and disposed of as soon possible to prevent accidental poisoning.

CONCESSION STAND SAFETY GUIDELINES

- No person **under the age of sixteen,** without adult supervision will be allowed behind the counter in the concession stands.
- People working in the concession stands will be trained in safe food preparation. Training will cover safe use of the equipment. This training will be provided by the Concession Stand Manager) and given to Team Mom's and Team Parents in the beginning of the season.
- Cooking equipment will be inspected periodically and repaired/replaced if need be.
- Propane tanks will be turned off at the grill and at the tank after use.
- Food not purchased by DLL to sell in its concession stands will not be cooked, prepared, or sold in the concession stands.
- Cooking grease will be stored safely in containers away from open flames.
- Carbon Dioxide tanks will be secured with chains so they stand upright and can't fall over. Report damaged tanks or valves to the supplier and discontinue use.
- Cleaning chemicals must be stored in a locked container.
- A Certified Fire Extinguisher suitable for grease fires must be placed in plain sight at all times.
- All concession stand workers are to be instructed on the use of fire extinguishers.
- All concession stand workers will be instructed on Abdominal Thrusts.
- A fully stocked First Aid Kit will be placed in each Concession Stand.
- The concession stand main entrance door will not be locked or blocked while people are inside.

CLEAN HANDS FOR CLEAN FOODS

Since the food handlers in 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 paper towel instead of your bare hands.

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

- After touching bare human body parts other than clean hands and clean, exposed portions of the 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 other activities that contaminate hands.

THE TOP SIX CAUSES FOR FOOD-BORNE ILLNESSES

- INADEQUATE COOLING AND REFRIGERATION.
- PREPARING FOOD TOO FAR IN ADVANCE FOR SERVICE.
- POOR PERSONAL HYGIENE, NOT PRACTICING PROPER HANDWASHING WHILE HANDLING OPEN FOODS, AND INFECTED PERSONNEL HANDLING FOODS.
- INADEQUATE REHEATING.
- INADEQUATE HOT HOLDING.
- CONTAMINATED RAW FOODS AND INGREDIENTS.

12 STEPS TO SAFE AND SANITARY FOOD SERVICE

Following these simple guidelines will help minimize the risk of food borne illness.

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.

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

Reheating. Rapidly reheat potentially hazardous foods to 165°F. Do not attempt to heat foods in crock pots, steam tables, over sterno units or with other hot holding devices. Slow-cooking mechanisms may activate bacteria and may never reach killing temperatures. Make sure to monitor proper temperatures.

Cooling and Cold Storage. Foods that require refrigeration must be cooled to 41°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), stir 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 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.

Dishwashing. Use disposable utensils for food service. Keep your hands away from food contact surfaces, and never reuse disposable dishware. Dishes and utensils that will be re-used (or are

used in your food preparation processes) should be washed in a 4-step process: (1) washing in hot, soapy water; (2) rinsing in clean water; (3) chemical or heat sanitizing; (4) and air-drying.

Hand washing. Frequent and thorough hand washing remains the first line of defense in preventing food borne disease. The use of disposable gloves (or hand sanitizers) can provide an additional barrier to contamination, but they are no substitute for hand washing! Hand washing should be made available in the actual area where open foods are being handled.

Health & Hygiene. Only healthy workers should handle, 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 to participate in any event involving open food handling. Workers should wear clean outer garments and should not smoke or consume food in the preparation area. The use of hair restraints is recommended to prevent unwanted hair ending up in food products.

Food Handling. Avoid bare hand contact with raw, ready-to-eat foods and food contact surfaces. Use an acceptable dispensing utensil or glove to handle or serve food. Touching food with bare hands can transfer germs to food.
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.
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 when operating outdoors.
Insect Control and Waste. Keep foods covered to protect them from insects when operating outdoors. Store pesticides away from food. 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.
Food Storage and Cleanliness. Keep foods stored off the floor/ground at least 6 inches. After your food service is finished, clean the concession area and discard unusable food.

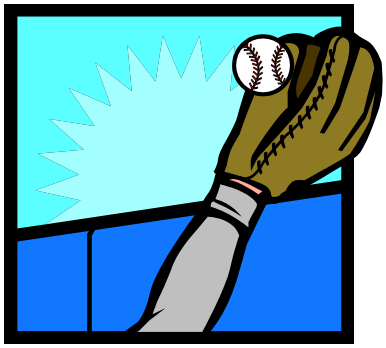
Note: These guidelines were obtained from the Fort Wayne-Allen County Department of Health FOOD PROTECTION DIVISION 1 E. Main Street, 5th Floor, Fort Wayne, IN 46802 (260) 449-7561 www.fw-ac-deptofhealth.com

ADDITIONAL SAFETY INFORMATION

Danville Little League goes to great lengths to provide as much training as possible. Attend as many of the clinics as possible.

Check the Danville Little League website frequently. Lots of information and a complete league calendar can be found there. The website can be a very valuable resource:
www.danvillelittleleague.net

Remember, safety is everyone's job. Prevention is the key to reducing accidents to a minimum. Report all hazardous conditions to the Safety Director or another Board member immediately. Don't 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.



DANVILLE LITTLE LEAGUE TRAINING SCHEDULE

MANAGER, COACH, PARENT, UMPIRE AND PLAYER TRAINING

Danville Little League prides itself in the training opportunities for Managers, Coaches and Players before and during the season. The Manager/Coach/Umpire clinics are required and failure to attend may prevent future manager/coach/umpire opportunities. Any questions should be directed to Training Chair, or the individual Division Directors.

POSITIVE COACHING ALLIANCE PROGRAM

TBD - Coaching for Winning and Life Lessons - Sycamore Main Clubhouse

Baseball Group Coaches Training

Jan. 28th and Continued	Majors/AAA/ AA Managers and Coaches	Various Locations
TBD	A/Farm/Rookie/TBall Managers and Coaches	Various Locations

Big Al Coaching Clinics

01/26 9:00 -12:00 PM	Coaches & Parents for Ages 5 - 8	Dougherty Valley High School
01/26 12:30 – 4:30 PM	Coaches & Parents for Ages 9 - 12	Dougherty Valley High School

Scorekeepers' Clinic

TBD Location TBD

DLL CPR & AED Certification:

March 14th – 7:00 PM – 9:00 PM – John Baldwin (Managers/Coaches)

DLL Safety, First Aid and Emergency Clinics:

Feb 28th – 7:00 PM – 8:00 PM – Baldwin Library (All Managers & Coaches)

UMPIRE TRAINING

Training for first year umpires for the season is as follows:

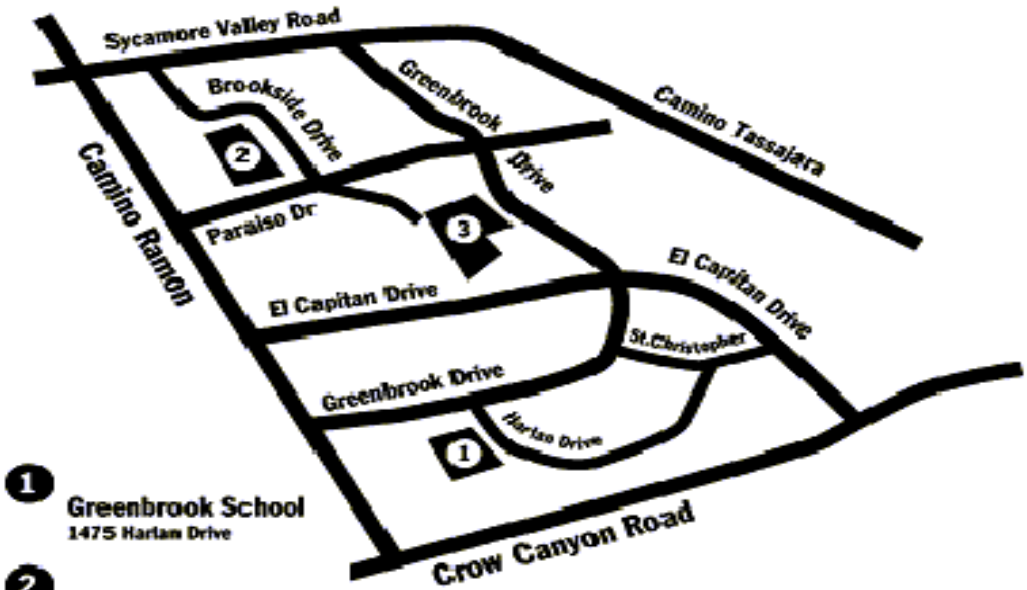
- Rules training - will be held on Jan 22 at the John Baldwin Library.

HAVE YOU:

- ☑ Walked field for debris/foreign objects
- ☑ Inspected helmets, bats, catchers' gear
- ☑ Made sure a First Aid kit is available
- ☑ Checked conditions of fences, backstops, bases and warning track
- ☑ Made sure a working telephone is available
- ☑ Held a warm-up drill

Danville

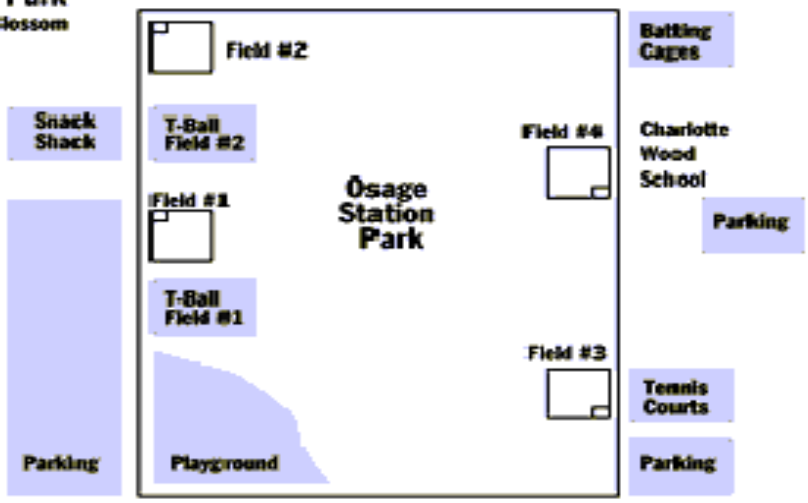
LITTLE LEAGUE PLAYING FIELDS



1 **Greenbrook School**
1475 Harlan Drive

2 **John Baldwin Elementary**
741 Brookside Drive

3 **T-Ball, AAA, Majors & Jrs**
Osage Station Park
Brookside/Orange Blossom




Make Sure They Are Safe!
"Dangling"
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."

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

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.

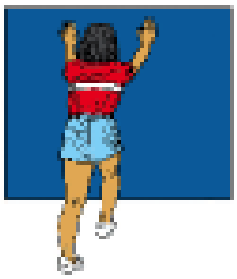
Hints on Stretching

- Stretch necks, backs, arms, thighs, legs and calves.
- Don't ask the child to stretch more that 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

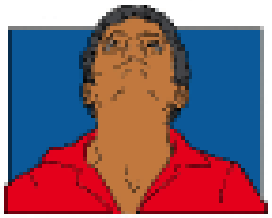
- Repetitions of at least 10.
- Have kids synchronize their movements.
- Vary upper body with lower body.
- Keep the pace up for a good cardio-vascular workout.

Suggestions for Warm-up Drills



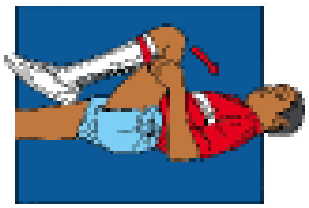
Heel Cord Stretches

Lean against a wall. Reach one leg behind you. Keep the knee straight, foot on the ground, and toes pointed forward. Slightly bend the leg that's closer to the wall. Lean forward. You should feel the stretch along the back of your calf. Repeat with other leg.



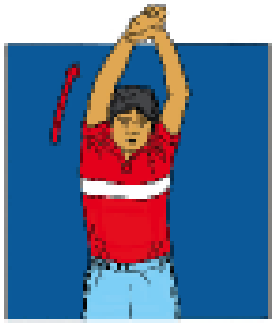
Head and Neck Circles

Make a circle with your head, going around 8-10 in one direction five times. Then reverse and make five circles in the opposite direction.



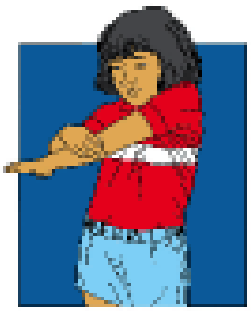
Low Back Stretches

Lie on your back, bring one knee up, and pull the knee closely toward your chest. Hold and repeat three times. Switch legs and repeat.



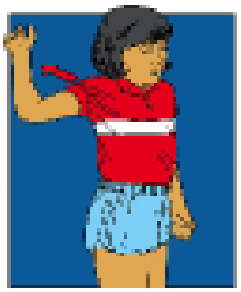
Shoulder Stretches #1

Stand or sit, holding your throwing arm at the wrist with your other hand. Put your arm over your head and push gently, feeling your upper arm against your head. You should feel the stretch inside your shoulder.



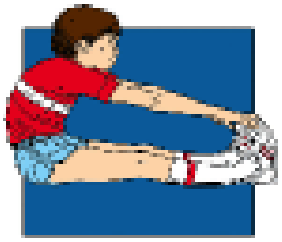
Shoulder Stretches #2

Stand or sit, hooking onto the elbow of your throwing arm with your other hand. Gently pull your throwing arm across your chest. You should feel the stretch below your shoulder, especially at the back.



Shoulder Stretches #3

Stand or sit with your pitching arm out to the side and your elbow bent. Move your arm back until you feel the stretch in the front of your shoulder.



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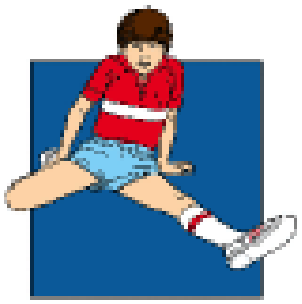
Thigh Stretches #1

Sit on the ground, stretch both legs out in front of you. Reach forward, touching your toes. Eventually you want to learn forward far enough to put your head on you knees. You should feel the stretch along the backs of your legs.

Thigh Stretches #2

Sit on the ground with one leg stretched out in front of you. Bend the other knee and put your foot behind you. Lean backwards. You should feel the stretch along the front of your thigh.



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. Water is the best fluid to keep the body well hydrated. 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.

PITCHING

Pitch count does matter. Every year we provide managers and coach's information about pitching injuries and how to prevent them. Remember, in the major leagues, a pitcher is removed after approximately 100 pitches. ***A child cannot be expected to perform like an adult! In 2019 Little League requires that all teams comply with mandatory pitch count rules. These rules are designed to protect your child's arm and will be enforced!!***

NEW PITCH COUNT RULES: The Little League pitch count rules are set forth in detail in the Little League International Official 2019 Rules and Regulations and will be enforced by Danville Little League.

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 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 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 of the elbow, compressive forces can damage the two bony surfaces 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 shown that

curveballs cause most problems at the inside of the elbow due to the sudden contractive forces of the wrist muscle. 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 vs. 27% in pitchers with a vertical delivery style.

Scientific Studies HAVE DEMONSTRATED THE FOLLOWING:
1) A significantly higher risk of **elbow** injury occurred after pitchers reached 50 pitches/outing.
2) A significantly higher risk of **shoulder** injury occurred after pitchers reached 75 pitches/outing.
3) In one season, a **total of 450 pitches or more** led to cumulative injury to the elbow and the shoulder.
4) The mechanics, whether good or bad, **did not** lead to an increased incidence of arm injuries.
5) The preliminary data suggest that throwing curveballs increases risk of injury to the shoulder more so than the elbow; however, subset analysis is being undertaken to investigate whether or not the older children were the pitchers throwing the curve.
6) The pitchers who limited their pitching repertoire to the fastball and change-up had the lowest rate of injury to their throwing arm.
7) A slider increased the risk of **both elbow and shoulder** problems.

Based on this research, DLL recommends against the teaching or throwing of curveballs under the age of 13. If a curveball is taught, the manager should instruct the child to throw the curveball like a football without snapping the arm or the wrist. If the manager or coach is unsure how to do this, he/she can consult teaching materials in the clubhouse or contact a DLL board member for further instruction.

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. If the manager or coach is unsure how to do this, he/she should contact a DLL board member for further instruction.

Children should not be encouraged to "play through pain." Pain is a warning sign of injury. Ignoring it can lead to greater injury.

HEALTH AND MEDICAL – GIVING 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 (911 paramedics). At no time should anyone administering First-Aid *go beyond* his or her capabilities. ***Know your limits!*** The average response time on 911 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.

First Aid-Kits
First Aid Kits will be furnished to each field at the beginning of the season.
To ***replenish materials*** in the First Aid Kit, the manager must contact the DLL Safety Director.

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 to 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 ***911***.
◊ 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.

Treatment At Site

Do . . .

 Access the injury. If the victim is conscious, find out what happened, where it hurts, watch for shock.
 Know your limitations.
 Call 911 immediately if person is unconscious or seriously injured.
 Look for signs of *injury (blood, black-and-blue, deformity of joint etc*.)
 Listen to the injured player describe what happened and what hurts if conscious. Before questioning, you may have to calm or soothe an excited child.
 Feel gently and carefully the injured area for signs of swelling or grating of broken bone.
 Talk to your team afterwards about the situation if it involves them. 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 procedure (CPR, etc.)
- Transport injured individual except in extreme emergencies.

If the injured person is unconscious, call 911 immediately.
Sometimes a conscious victim will tell you not to call an ambulance, and you may not be sure what to do. Call 911 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.
- Has seizures, a severe headache, or slurred speech.
- Appears to have been poisoned.
- Has injuries to the head, neck or back.
- Has possible broken bones.

If you have any doubt at all, call 911 and request paramedics.

CHECKING THE VICTIM

Conscious Victims:

If the victim is conscious, ask what happened.
Look for other life-threatening conditions and conditions that need care or might become life threatening.
The victim may be able to tell you what happened and how he or she feels. This information helps determine what care may be needed.

1) Talk to the victim and to any people standing by who saw the accident take place.
2) Check the victim from head to toe, so you do not overlook any problems.
3) Do not ask the victim to move, and do not move the victim yourself.
4) Examine the scalp, face, ears, nose, and mouth.
5) Look for cuts, bruises, bumps, or depressions.
6) Watch for changes in consciousness.
7) Notice if the victim is drowsy, not alerts, or confused.
8) Look for changes in the victim's breathing. A healthy person breathes regularly, quietly, and easily. Breathing that is not normal includes noisy breathing such as gasping for air; making rasping, gurgling, or whistling sounds; breathing unusually fast or slow; and breathing that is painful.
9) Notice how the skin looks and feels. Note if the skin is reddish, bluish, pale or gray.
10) Feel with the back of your hand on the forehead to see if the skin feels unusually damp, dry, cool, or hot.
11) Ask the victim again about the areas that hurt.
12) Ask the victim to move each part of the body that doesn't hurt.
13) Check the shoulders by asking the victim to shrug them.
14) Check the chest and abdomen by asking the victim to take a deep breath.
15) Ask the victim if he or she can move the fingers, hands, and arms.
16) Check the hips and legs in the same way.
17) Watch the victim's face for signs of pain and listen for sounds of pain such as gasps, moans or cries.
18) Look for odd bumps or depressions.
19) Think of how the body usually looks. If you are not sure if something is out of shape, check it against the other side of the body.
20) Look for a medical alert tag on the victim's wrist or neck. A tag will give you medical information about the victim, care to give for that problem, and who to call for help.

21) When you have finished checking, if the victim can move his or her body without any pain and there are no other signs of injury, have the victim rest sitting up.
22) When the victim feels ready, help him or her stand up.

Parent/Athlete Concussion Information Sheet

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by bump, blow, or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.
If an athlete reports **one or more** symptoms of concussion listed below after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

Did You Know?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

SIGNS OBSERVED BY COACHING STAFF	SYMPTOMS REPORTED BY ATHLETES
Appears dazed or stunned	Headache or "pressure" in head
Is confused about assignment or position	Nausea or vomiting
Forgets an instruction	Balance problems or dizziness
Is unsure of game, score, or opponent	Double or blurry vision
Moves clumsily	Sensitivity to light
Answers questions slowly	Sensitivity to noise
Loses consciousness (even briefly)	Feeling sluggish, hazy, foggy, or groggy
Shows mood, behavior, or personality changes	Concentration or memory problems
Can't recall events prior to hit or fall	Confusion
Can't recall events after hit or fall	Just not "feeling right" or "feeling down"

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that not only does not diminish, but gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

Remember

Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

It's better to miss one game than the whole season. For more information on concussions, visit:
www.cdc.gov/Concussion

CPR

The basic CPR steps include:

1. **Recognize the emergency (tap and shout)**
2. **Activate EMS (call 9-1-1)**
3. **Check for breathing**
4. **Compressions: Provide 30 compressions**
5. **Airway: Open the victim's airway**
6. **Breathing: Give 2 breaths**
7. **Continue till help arrives**

Recognize the Emergency (Tap & Shout)

Category	Age Range	Technique	Location	Depth
Adult	From signs of puberty and up	2 Hands	Center of the chest between the nipples	At least 2 inches
Child	Age 1 to when signs of puberty are present	1 or 2 hands	Center of the chest between the nipples	About 2 inches
Infant	Up to age 1 (based on size and weight)	2 fingers	Center of the chest, about 1 finger-width below the nipples	About 1½ inches

A victim of SCA will suddenly collapse. Assess the scene for safety. If it's safe approach the victim from the side.

Attempt to establish a response by tapping on the victim's shoulder and shouting loudly, "Hey! Hey, are you okay?" It the victims is unresponsive this is an emergency. You don't need to know if he is breathing or not, what you do know is that he won't respond to your tap and shout (victim is unresponsive) so you need to get help right away.

Activate EMS (call 9-1-1)

If there is a bystander, point at the person and say, "You, go call 9-1-1 and come right back." If the location has an AED, then state, "You, go call 9-1-1, get the AED and come right back." If there is more than one bystander you can split the duties – send one to call 9-1-1 and another to get the AED.

If you are alone with an adult victim, you will need to go call 9-1-1, get the AED and come right back.

If you are alone with a child or infant you will provide CPR for 2 minutes before leaving to call 9-1-1. During that time yell for help; if bystanders do come then send them to call 9-1-1. If you are alone after two minutes and there is no suspected injury, carry the child or infant to the phone to call 9-1-1. If injury is suspected, go get the phone, call 9-1-1 and quickly return to the child.

Check for Breathing

Look at the victim's chest for 5-10 seconds to evaluate breathing. For adults, look for normal breathing (gasping or irregular breathing is not normal); for a child look for any breathing. If there is no normal breathing for an adult or no breathing for a child or infant after 5-10 seconds then start CPR beginning with chest compressions.

There is no pulse check for workplace or community rescuers. If there is no breathing, the victim needs CPR – a pulse check wastes time because it's often inaccurate (when attempted by lay providers) and delays the start of compressions.

C-A-B Sequence

Rescuers use the C-A-B sequence to remember the sequence of CPR steps. C-A-B stands for: Compression, Airway and Breathing.

Compressions: Provide 30 compressions

Compressions need to be hard and fast. The victim needs to be on a firm flat surface. Use the following techniques: Chest compressions are the most important part of CPR. Most rescuers do not press hard enough. The earlier compressions are started, and the quality of compressions makes a huge impact on surviving SCA. To provide effective compression:

- **Press hard and fast**
  - At a rate of at least 100 beats per minute
  - The song "Staying Alive" is 100 beats per minute
  - Ensure the victim is lying on a firm, flat surface
- **Minimize interruptions**
  - It takes many consecutive compressions to achieve blood flow to the brain
  - Interruption to compression reduces blood flow
  - Take no more that 10 seconds to deliver breaths between cycles of 30 compressions
- **Ensure full recoil of the chest**
  - Allow the chest to rebound fully between each compression
  - Take your full weight off the victim's chest while keeping your hands in contact with the chest

Airway: Position the head for rescue breaths

Place one hand on the forehand and 2 or 3 fingers of the other hand on the bony structure of the victim's jaw. Quickly tilt the head and lift the chin to open the airway.

A victim's own tongue is the most common cause of airway blockage in an unresponsive victim. When a victim is unresponsive and flat on his back, the tongue falls into the back of the throat and blocks the airway. Titling the head and lifting the chin positions the tongue out of the way to allow air to flow from the reducer's lips past the victim's trachea and into the victim's lungs.

Breathing: Give two rescue breaths

Maintain the head tilt/chin lift position, pinch the victim's nose and seal your mouth over the victim's mouth. For an infant, cover the victim's mouth and nose with your mouth (do not pinch the nose).

Breathe into the victim's mouth for about one second. Keep your eye towards the victim's chest to watch for chest rise. Once the chest starts to rise, that's enough air. Break the seal and repeat the process for a second breath.

Do not breath too fast, too hard or too much air into the victim. Over inflation of the chest forces air into the victim's stomach and causes vomiting. If the victim vomits during CPR, roll them to the side, clear out the mouth, roll them back and continue CPR.

Remember, it should take no more than 10 seconds to open the airway, give two breaths and resume compressions.

Repeat the C-A-B Sequence

Maintain CPR for as long as possible. Continue CPR in cycles of 30 compressions and 2 breaths (30:2).

Never stop CPR to recheck the victim's breathing. Only stop if:

- The victim begins to move
- Help arrives and is ready to take over
- An AED is ready to use (powered on, pads placed on the victim and prompting you to stop CPR)
- You are exhausted and cannot continue

HOW TO USE AN AED:

First, power on the AED. An AED can be used on an adult, child, or infant. Follow the AED prompts. Place the AED near the victim's head and power on the unit. Some models require you to push a button to turn it on, while others turn on automatically when you lift the lid.

Second, apply the AED pads. Expose the chest and wipe it dry of any moisture. Apply the pads to the chest according to the pads.

- Place one pad on the right side of the chest, just below the collarbone
- Place the other pad on the lower left side of the chest
- Connect the pads to the AED if they're not already connected

If there are two trained rescuers, one performs CPR while the other prepares the AED for use. The rescuer in charge of the AED will apply the pads around the hands of the person giving chest compressions. Do not stop CPR while the AED is being readied for use. The AED will prompt you to stop CPR when it is ready to analyze the heart rhythm.

Third, clear the victim and shock. It is critical that no one touches the victim or his clothing while the AED analyzes or delivers a shock.

When prompted by the AED to deliver a shock:

- The AED user quickly looks up and down the entire victim to ensure no one is touching him and loudly states, "Everybody clear."
- The rescuer can now push the shock button.

HOW TO USE AN AED ON A CHILD:

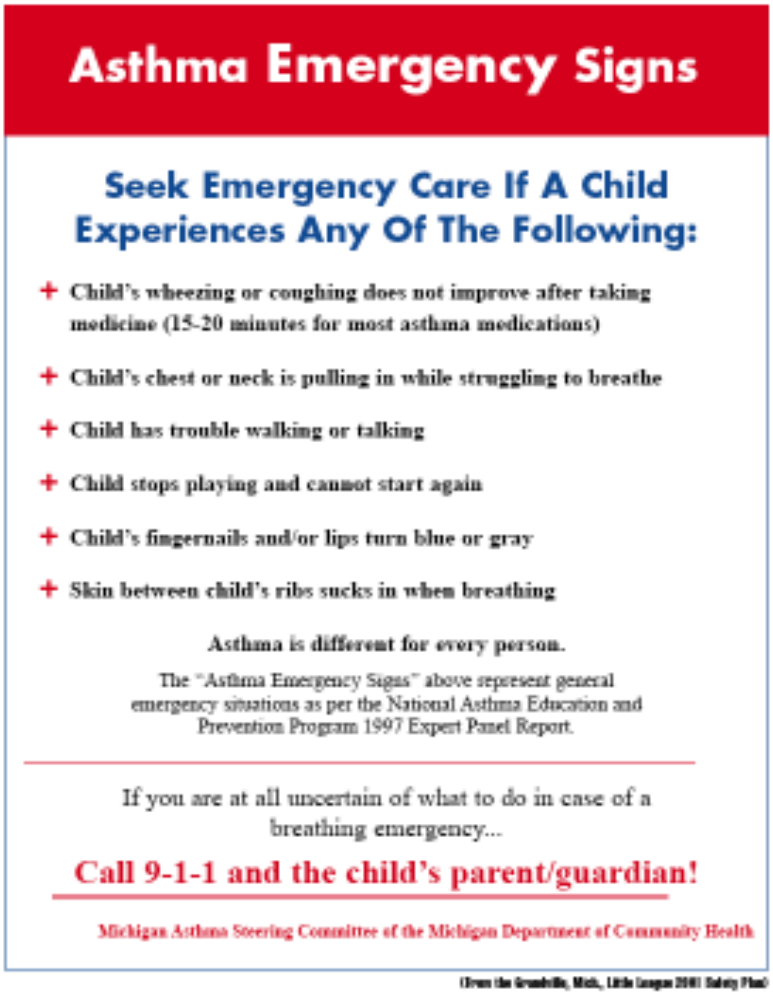
For the purpose of AED use, a child is age 1-8, or weighs less than 55 lbs. An infant is less than 1 year old. Children and infants require a lower level of energy to defibrillate the heart.

Child victim: Use an AED with pediatric pads or equipment. If these are not available, use an AED with adult pads and settings.

Infant victim: It's best to use a manual defibrillator. If one is not available, use an AED with pediatric pads or equipment. If these are not available, use an AED with adult pads and settings.

ASTHMA AND ALLERGIES

Many children suffer from asthma and/or allergies (allergies especially in the springtime). Allergy symptoms can manifest themselves to look like the child has a cold or flu while children with asthma usually have a difficult time breathing if they become active. Allergies are usually treated with prescription medication. If a child is allergic to insect stings/bites or certain types of food, you must know about it because these allergic reactions can become life threatening. Encourage parents to fill out the medical history forms. Study their comments and know which children on your team need to be watched. Likewise, a child with asthma needs to be watched. If a child starts to have an asthma attack, have him stop playing immediately and calm him down until he/she is able to breathe normally. If the asthma attack persists, dial 911 and request emergency service.



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 wound. Check pulse to be sure bandage is not too tight.
4) If bleeding is not controlled by use of direct pressure, **apply a tourniquet** only as a last resort and call 911immediately.

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 prevent scars**.

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 head so water does not drain into uninjured eye. Lift eyelid away from 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.

Sunburn:

If victim has been sunburned,
1) Treat as you would any major burn (see above).
2) Treat for shock if necessary (see section on "Caring for Shock")
3) Cool victim as rapidly as possible by applying cool, damp cloths or immersing in cool, not cold water.
4) Give victim fluids to drink.
5) Get professional medical help immediately for severe cases.

CHOKING

Partial Obstruction with Good Air Exchange:

Symptoms may include forceful cough with wheezing sounds between coughs.
Treatment: Encourage victim to cough as long as good air exchange continues. DO NOT interfere with attempts to expel object.

Partial or Complete Airway Obstruction in Conscious Victim:

Symptoms may include: Weak cough; high-pitched crowing noises during inhalation; inability to breathe, cough or speak; gesture of clutching neck between thumb and index finger; exaggerated breathing efforts; dusky or bluish skin color.
Treatment –

Abdominal Thrusts

A choking victim can't speak or breathe and needs your help immediately. Follow these steps to help a choking victim:

1. From behind, wrap your arms around the victim's waist.
2. Make a fist and place the thumb side of your fist against the victim's upper abdomen, below the ribcage and above the navel.
3. Grasp your fist with your other hand and press into their upper abdomen with a quick upward thrust. Do not squeeze the ribcage; confine the force of the thrust to your hands.
4. Repeat until object is expelled.

UNCONSCIOUS CHOKING VICTIM:

1. GIVE RESCUE BREATHS
Retilt the head and give another rescue breath.
2. GIVE 30 CHEST COMPRESSIONS
If the chest still does not rise, give 30 chest compressions.
3. LOOK FOR AND REMOVE OBJECT IF SEEN
4. GIVE 2 RESCUE BREATHS
5. WHAT TO DO NEXT
■IF BREATHS DO NOT MAKE THE CHEST RISE—Repeat steps 2 through 4.
■IF THE CHEST CLEARLY RISES—CHECK for breathing. Give CARE based on conditions found.

COLDS AND FLU

The baseball season usually coincides with the cold and flu season. There is nothing you can do to help a child with a cold or flu except to recognize that the child is sick and should be at home recovering and not on the field passing his cold or flu on to all your other players. **Prevention** is the solution here. Don't be afraid to tell parents to keep their child at home.

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 911 and treat the player until professional medical help arrives.

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.

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 tooth, gently rinse with water.

3) If possible, re-implant and stabilize by biting down gently on a towel or handkerchief. Do this only if 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.

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)

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.

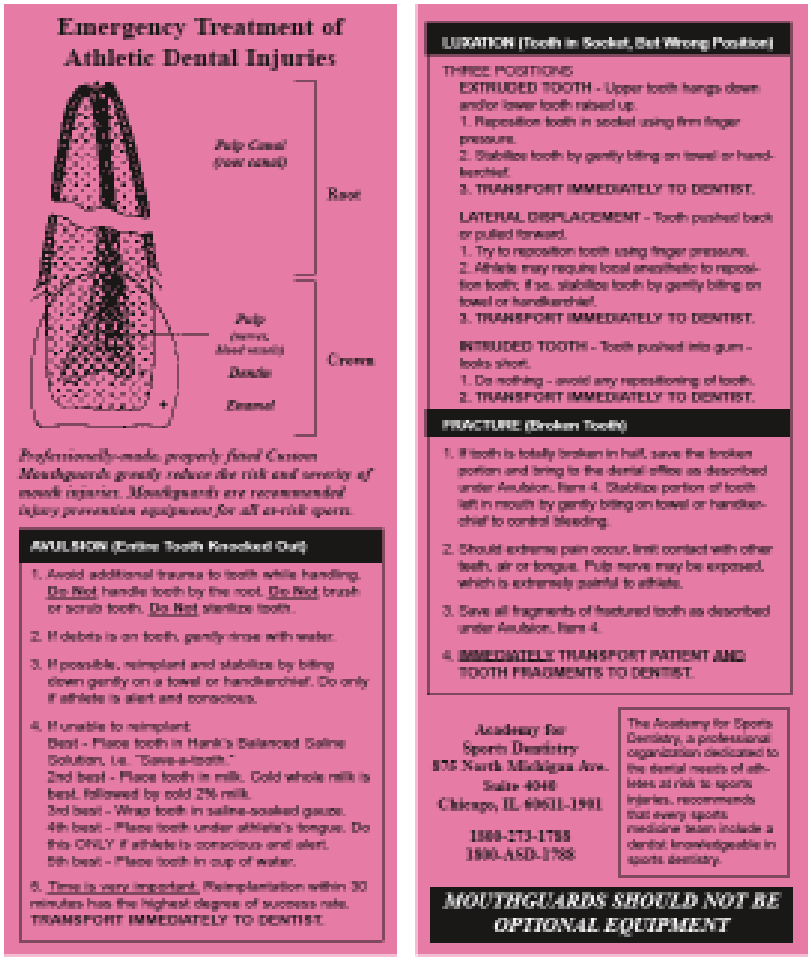
INTRUDED TOOTH - Tooth pushed into gum - looks short.

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. 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.
4) IMMEDIATELY TRANSPORT PATIENT AND TOOTH FRAGMENTS TO DENTIST in the plastic baggie supplied in your First-Aid kit.



Emergency Treatment of Athletic Dental Injuries

Pulp Canal (root canal)
Root
Pulp (Nerves, blood vessels)
Dentin
Enamel
Crown

Professionally-made, properly fitted Custom Mouthguards greatly reduce the risk and severity of mouth injuries. Mouthguards are recommended injury prevention equipment for all at-risk sports.

AVULSION (Entire Tooth Knocked Out)

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2. If debris is on tooth, gently rinse with water.
3. If possible, reimplant and stabilize by biting down gently on a towel or handkerchief. Do only if athlete is alert and conscious.
4. If unable to reimplant:
   Best - Place tooth in Hank's Balanced Saline Solution, i.e. "Save-a-tooth."
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   3rd best - Wrap tooth in saline-soaked gauze.
   4th best - Place tooth under athlete's tongue. Do this ONLY if athlete is conscious and alert.
   5th best - Place tooth in cup of water.
5. Time is very important. Reimplantation 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. Athlete 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 by gently biting on 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.

Academy for Sports Dentistry
875 North Michigan Ave.
Suite 4048
Chicago, IL 60611-1901

1-888-273-1788
1-800-ASD-1788

The Academy for Sports Dentistry, a professional organization dedicated to the dental needs of athletes at risk to sports injuries, recommends that every sports medicine team include a dental knowledgeable in sports dentistry.

MOUTHGUARDS SHOULD NOT BE OPTIONAL EQUIPMENT

HEAD AND SPINE INJURIES

Symtoms 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 ears.

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 till paramedics arrive and take over care.

HEAT EXHAUSTION

Symptoms may include fatigue, irritability, headache, faintness, weak or rapid pulse, shallow breathing, cold clammy skin, profuse perspiration.

Treatment:

1) Instruct victim to lie down in a cool, shaded area or an air-conditioned room. Elevate feet.
2) Massage legs toward heart.
3) Only if victim is conscious, give cool water or electrolyte solution every 15 minutes.
4) Use caution when letting victim first sit up, even after feeling recovered.

HEAT STROKE / SUNSTROKE

Symptoms may include: extremely high body temperature (106F or higher); hot, red, dry skin; absence of sweating; rapid pulse; convulsions; unconsciousness.

Treatment:

1) Call 911 immediately.
2) Lower body temperature quickly by placing victim in partially filled tub of cool, not cold, water (avoid over-cooling). Briskly sponge victim's body until body temperature is reduced then towel dry. If tub is not available, wrap victim in cold, wet sheets or towels in a well ventilated room or use fans and air conditioners until body temperature is reduced.
3) **Do Not** give stimulating beverages such as coffee, tea or soda.

HEART ATTACK

Signals of a Heart Attack

Heart attack pain is most often felt in the center of the chest, behind the breastbone. It may spread to the shoulder, arm or jaw. Signals of a heart attack include:

nPersistent chest pain or discomfort - Victim has persistent pain or pressure in the chest that is not relieved by resting, changing position, or oral medication. Pain may range from discomfort to an unbearable crushing sensation.

nBreathing difficulty

 Victim's breathing is noisy.

 Victim feels short of breath.

 Victim breathes faster than normal.

nChanges in pulse rate

 Pulse may be faster or slower than normal

 Pulse may be irregular.

 Victim's skin may be pale or bluish in color.

 Victim's face may be moist.

 Victim may perspire profusely.

 The absence of a pulse is the main signal of a cardiac arrest.

nThe number one indicator that someone is having a heart attack is that he or she will be in denial. A heart attack means certain death to most people. People do not wish to acknowledge death therefore they will deny that they are having a heart attack.

Care For A Heart Attack

1) Recognize the signals of a heart attack.
2) Convince the victim to stop activity and rest.
3) Help the victim to rest comfortably.
4) Try to obtain information about the victim's condition.
5) Comfort the victim.
6) Call 911 and report the emergency.
7) Assist with medication, if prescribed.
8) Monitor the victim's condition.
9) Be prepared to give CPR if the victim's heart stops beating.

INSECT STINGS

In highly sensitive persons, do not wait for allergic symptoms to appear. Get professional medical help immediately. Call911. If breathing difficulties occur, start rescue breathing techniques; if pulse is absent, begin CPR.

Allergic Reaction Symptoms:

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

Treatment:

1) For mild or moderate symptoms, wash with soap and cold water.
2) Remove stinger or venom sac by gently scraping with fingernail or business card. Do not remove stinger with tweezers as more toxins from the stinger could be released into the victim's body.
3) If victim has gone into shock, treat accordingly (see section, "Care for Shock").

MUSCLE, BONE OR JOINT INJURIES

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 911, all you can do is comfort the victim, keep him/her warm and still and treat for shock if necessary (see "Caring for Shock" section)

Osgood Schlaughter's Disease

Osgood Schlaughter's Disease is the "growing pains" disease. It is very painful for kids that have it. In a nutshell, the bones grow faster than the muscles and ligaments. A child must outgrow this disease. All you can do is make it easier for him or her by:

1) Icing the painful areas.
2) Making sure the child rests when needed.
3) Using Ace or knee supports.

When treating an injury, remember:

Protection
Rest
Ice
Compression
Elevation
Support

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 object to keep it from moving.
3) Bandage the dressings in place around the object.
4) If object penetrates chest and victim complains of discomfort or pressure, quickly loosen bandage on one side and reseal. Watch carefully for recurrence. Repeat procedure if necessary.
5) Treat for shock if needed (see "Care for Shock" section).
6) Call 911 for professional medical care.

POISONING

Call 911 and Poison Control 1-800-222-1222

1) **Do not** give any First Aid if victim is **unconscious** or is having convulsions. Begin rescue breathing techniques or CPR if necessary. If victim is convulsing, protect from further injury; loosen tight clothing if possible.
2) If professional medical help does not arrive immediately:

Do Not induce vomiting if poison is unknown, a corrosive substance (i.e., acid, cleaning fluid, lye, drain cleaner), or a petroleum product (i.e., gasoline, turpentine, paint thinner, lighter fluid).

3) Take poison container (or vomitus if poison is unknown) with victim to hospital.

SHOCK

Shock is likely to develop in any serious injury or illness. Signals of shock include:

- Restlessness or irritability
- Altered consciousness
- Pale, cool, moist skin
- Rapid breathing
- Rapid pulse.

Caring for shock involves the following simple steps:

1) Have the victim lie down. Helping the victim rest comfortably is important because pain can intensify the body's stress and accelerate the progression of shock.
2) Control any external bleeding.
3) Help the victim maintain normal body temperature. If the victim is cool, try to cover him or her to avoid chilling.
4) Try to reassure the victim.
5) Elevate the legs about 12 inches unless you suspect head, neck, or back injuries or possible broken bones involving the hips or legs. If you are unsure of the victim's condition, leave him or her lying flat.
6) Do not give the victim anything to eat or drink, even though he or she is likely to be thirsty.
7) Call 911 immediately. Shock can't be managed effectively by first aid alone. A victim of shock requires advanced medical care as soon as possible.

SPLINTERS

Splinters are defined as slender pieces of wood, bone, glass or metal objects that lodge in or under the skin. **If splinter is in eye, *DO NOT* remove it.**

1) First wash your hands thoroughly, then gently wash affected area with mild soap and water.
2) Sterilize needle or tweezers by applying disinfectant or heating tips in a flame; wipe off carbon (black discoloration) with a sterile pad before use.
3) Loosen skin around splinter with needle; use tweezers to remove splinter. If splinter breaks or is deeply lodged, consult professional medical help.
4) Cover with adhesive bandage or sterile pad, if necessary.

SUDDEN ILLNESS

Symptoms:

- Feeling light-headed, dizzy, confused, or weak
- Changes in skin color (pale or flushed skin), sweating
- Nausea or vomiting
- Diarrhea
- Changes in consciousness
- Seizures
- Paralysis or inability to move
- Slurred speech
- Impaired vision
- Severe headache
- Breathing difficulty
- Persistent pressure or pain.

Care For Sudden Illness:

1) Call 911
2) Help the victim rest comfortably.
3) Keep the victim from getting chilled or overheated.
4) Reassure the victim.
5) Watch for changes in consciousness and breathing.

6) Do not give anything to eat or drink unless the victim is fully conscious.
If the victim:
Vomits -- Place the victim on his or her side.
Faints -- Position him or her on the back and elevate the legs 8 to 10 inches if you do not suspect a head or back injury.
Has a diabetic emergency -- Give the victim some form of sugar.
Has a seizure -- Do not hold or restrain the person or place anything between the victim's teeth. Remove any nearby objects that might cause injury. Cushion the victim's head using folded clothing or a small pillow.

TRANSPORTING AN INJURED PERSON

If injury involves neck or back, ***DO NOT*** move victim unless absolutely necessary. Wait for paramedics.
If victim must be pulled to safety, move body lengthwise, not sideways. If possible, slide a coat or blanket under the victim:
a) Carefully turn victim toward you and slip a half-rolled blanket under back.
b) Turn victim on side over blanket, unroll, and return victim onto back.
c) Drag victim head first, keeping back as straight as possible.
If victim must be lifted:
Support each part of the body. Position a person at victim's head to provide additional stability. Use a board, shutter, tabletop or other firm surface to keep body as level as possible.

UNSAFE WEATHER

Thunderstorms and Lightning:
The average lightning stroke is 5-6 miles long with up to 30 million volts at 100,000 amps flow in less than a tenth of a second. The average thunderstorm is 6-10 miles wide and moves 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 strokes coming from the storm's overhanging anvil cloud. This fact is the reason that many lightning deaths and injuries occur with clear skies overhead. On average, the thunder from a lightning stroke can only be heard over a distance of 3-4 miles, depending on terrain, humidity and background noise around you. By the time you can hear the thunder, the storm has already approached to within 3-4 miles! The sudden cold wind that many people use to gauge the approach of a thunderstorm is the result of down drafts and usually extends less than 3 miles from the storm's leading edge. By the time you feel the wind, the storm can be less than 3 miles away!

If you can ***HEAR, SEE OR FEEL*** a ***THUNDERSTORM***:
1. ***Suspend all games and practices immediately***.
2. Stay away from metal including fencing and bleachers.
3. Do not hold metal bats.
4. Get players to walk, not run to their parent's or designated driver's cars and wait for your decision on whether or not to continue the game or practice.

Hot Weather:
Precautions must be taken in order to make sure the players on your team do not ***dehydrate*** or ***hyperventilate***.
1. Suggest players take drinks of water when coming on and going off the field between innings.
2. If a player looks distressed while standing in the hot sun, substitute that player and get him/her into the shade of the dugout A.S.A.P.

3. If a player should collapse as a result of heat exhaustion, call ***911*** immediately. Get the player to drink water and use the instant ice bags supplied in your First-Aid Kit to cool him/her down until the emergency medical team arrives. (*See Hydration*)

Ultra-Violet Ray Exposure:

This kind of exposure increases an athlete's risk of developing a specific type of skin cancer known as melanoma. DLL recommends the use of sunscreen with a SPF (sun protection factor) of at least 15 as a means of protection from damaging ultra-violet light.

OTHER PROCEDURES

COMMUNICABLE DISEASE PROCEDURES

While risk of one athlete infecting another with *HIV/AIDS* or the *hepatitis B or C virus* during competition is close to non-existent, there is a remote risk other blood borne infectious disease can be transmitted. Procedures for guarding against transmission of infectious agents should include, but not be limited to the following:

 A bleeding player should be removed from competition as soon as possible.

 Bleeding must be stopped, the open wound covered, and the uniform changed if there is blood on it before the player may re-enter the game.

 Routinely use gloves to prevent mucous membrane exposure when contact with blood or other body fluid is anticipated *(latex gloves are provided in First Aid Kit*).

 Immediately wash hands and other skin surface if contaminated with blood with antibacterial soap.

 Clean all blood contaminated surfaces and equipment with a 1:10 solution of Clorox Bleach.

 Managers, coaches, and volunteers with open wounds should refrain from all direct contact with others until the condition is resolved.

 Follow accepted guidelines in the immediate control of bleeding and disposal when handling bloody dressings, mouth guards and other articles containing body fluids. The virus cannot enter through the skin unless there is a cut or break in the skin. Even then, the possibility of infection is very low unless there is direct contact for a lengthy period of time. Currently, it is believed that saliva is not capable of transmitting HIV. The likelihood of HIV transmission during a First-Aid situation is very low. Always give care in ways that protect you and the victim from disease transmission.

 If possible, wash your hands before and after giving care, even if you wear gloves.

 Avoid touching or being splashed by another person's body fluids, especially blood.

 Wear disposable gloves during treatment.

Like AIDS, hepatitis B and C are viruses. Even though there is a very small risk of infecting others by direct contact, one must take the appropriate safety measures, as outlined above, when treating open wounds. There is now a vaccination against hepatitis B.

PRESCRIPTION MEDICATION PROCEDURE

Do not, at any time, administer any kind of prescription medicine. This is the parent's responsibility and DLL does not want to be held liable, nor do you, in case the child has an adverse reaction to the medication.

EVACUATION PROCEDURE

If an emergency should arise that would require evacuation, the manager will be responsible for implementing the following procedures:

1. All players will return to the dugout or other place designated by the manager and will wait for their parents to come and get them.
2. The manager and coaches will contact all parents of players to the extent reasonably possible to request that they immediately come and get their children. 3. If a player's parent is not attending the game, the manager will take responsibility for evacuating that child until picked up by the parent.

CHILD ABUSE

Volunteers are the greatest resource Little League has in aiding children's development into leaders of tomorrow. But some potential volunteers may be attracted to Little League to be near children for *abusive reasons*.

Anyone can be an *abuser* and it could happen *anywhere*. By educating parents, volunteers and children, you can help reduce the risk it will happen at Danville Little League. Like all safety issues, ***prevention*** is the key. DLL has a three-step plan for screening out possible child abuser volunteers.

Application: To include residence information, employment history and three personal references from non-relatives. All potential volunteers must fill out the application that clearly asks for information about prior criminal convictions. The form also points out that all positions are conditional based on the information received back from a background check.

Policy: DLL has a written policy that no known child-sex offender or felon will be given access to children in the Little League program.

Reference Checks: DLL will conduct record checks to make sure the information given by the applicant is corroborated by the records and/or references.

Reporting: In the unfortunate case that child sexual abuse is suspected, you should immediately contact the DLL President, or a DLL Board Member if the
President is not available, to report the abuse. DLL along with district administrators will contact the proper law enforcement agencies.

Investigation: DLL will appoint an individual with significant professional background to receive and act on abuse allegations. These individuals will act in a confidential manner, and serve as the League's liaison with the local law enforcement community. *Little League volunteers should not attempt to investigate suspected abuse on their own*.

Suspension/Termination: When an allegation of abuse is made against a Little League volunteer, it is our duty to protect the children from any possible further abuse by keeping the alleged abuser away from children in the program. Upon such an allegation, the accused person will be suspended from participating in DLL programs of any kind. If the allegations are substantiated, the next step is clear -- termination from all DLL activities, assuring that the individual will not have any further contact with the children in the League.

ADDITIONAL FORMS TO BE USED WITH THIS SAFETY PLAN:

2019 Volunteer Application Online
ASAP Newsletter
2019 Qualified Safety Plan Registration Form
Medical Release
Facility Survey
These forms are available at:
http://www.littleleague.org/programs/asap/index.asp

League Player Registration Data or Player Roster Data, Coach and Manager Data entered via Little League International Data Center