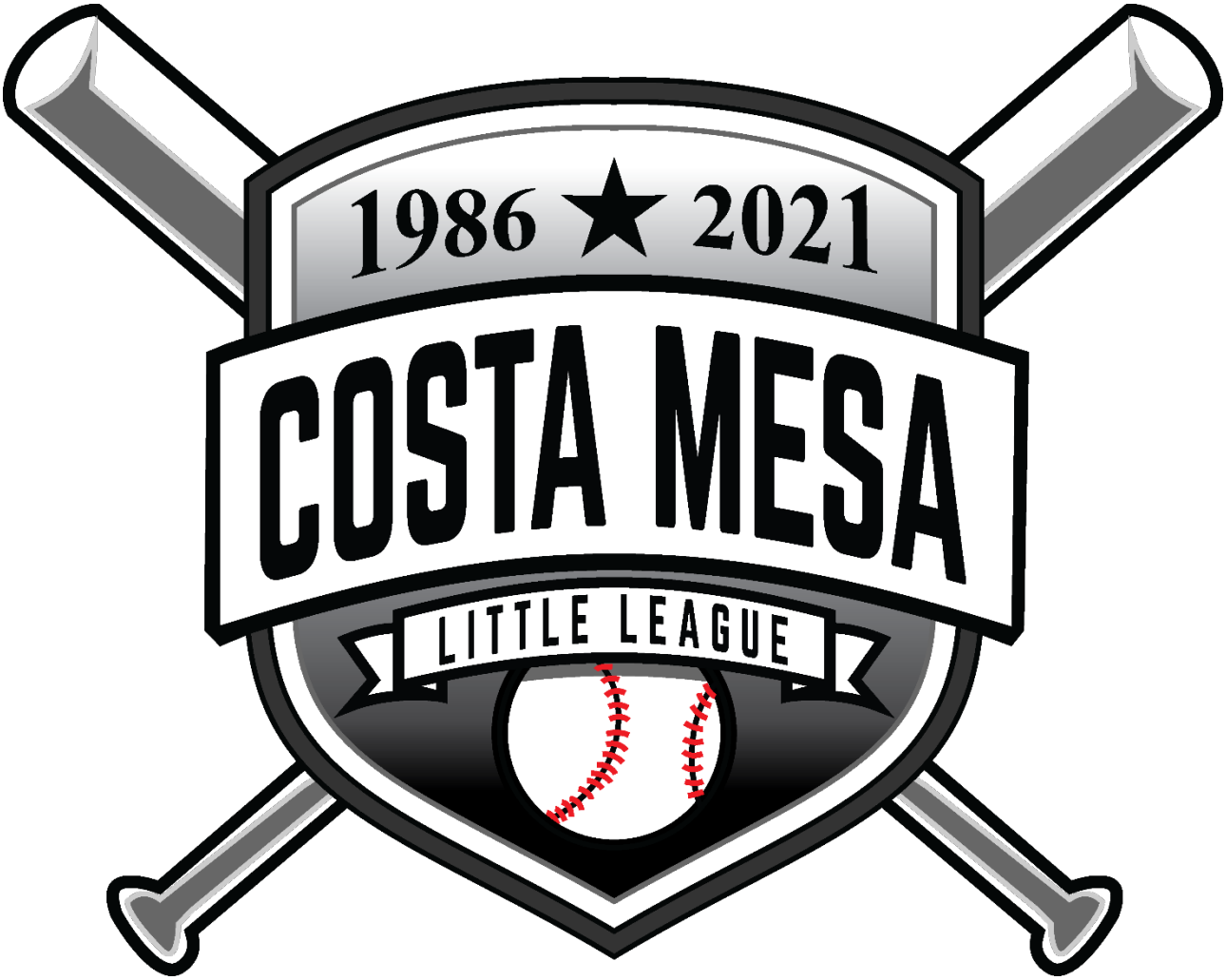

2024

Safety Guide

League ID # 405-62-02

2973 Harbor Boulevard, #456 · Costa Mesa, CA 92626 (949) 887-7011

CMLLbaseball.com

Costa Mesa Little League

"I will always do my best"

Table of Contents

This safety manual shall be kept with team manager's equipment at all times and copies shall be posted online, in the snack bar, and equipment sheds throughout the season

Emergency Numbers

Police Emergency/Emergency	911
Costa Mesa Police Non-Emergency	714-754-5252
National Poison Center	800-222-1222

CMLL Safety Officer
Reagan Berkley
858-699-0946

CMLL President
Brian Clarke
949-637-9267

LITTLE LEAGUE BASEBALL REQUIRES every Board Member, Coach, Manager, Umpire (and anyone else who has direct interaction with the children on behalf of our Little League program) complete the Volunteer application. C.M.L.L. uses the Little League Approved form. The League Safety Officer then runs background checks with the information provided, including Megan's Law checks and criminal status.

Remember, safety is everyone's job. Prevention is the key to reducing accidents to a minimum. Report all hazardous conditions to the Safety Officer or any Board member immediately. Do not play on a field or with equipment that is unsafe. Be sure your players are fully equipped at all times, especially catchers and batters. Also, check your team's equipment often.

Costa Mesa Little League

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Accident Reporting

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

When to report - All such incidents described above must be reported to the League Safety Officers within 24 hours of the incident.

Upper Division	Lower Division
(Majors, Minor A & Minor B, Minor C)	(Coach Pitch & Tee Ball)

Reagan Berkley
858-699-0946
reagan.berkley@gmail.com

How to make the report – Coaches are required to have with them at all times a Safety Awareness Incident/Injury Track report. All appropriate procedures are outlined in this form. If an incident occurs, fill out the report and contact your Safety Officer for further instructions within 24 hours. At a minimum, the following information must be provided:

The name and phone number of the individual involved, the date, time, and location of the incident, as detailed a description of the incident as possible, the preliminary estimation of the extent of any injuries. The name and phone number of the person reporting the incident.

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

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

Near Miss Reporting

To provide the safest environment possible, it is the leagues responsibility to work towards preventing incidents. If a near miss occurs in your presence please report this to your Safety Officer (via e-mail) along with any suggestions on how the incident could be prevented in the future. This will be reviewed by the Safety Officer along with the appropriate board members to set additional measures of safety into effect.

THE INJURY REPORTING FORM MUST BE SUBMITTED FOR EVERY (major or minor) INJURY WHICH OCCURS DURING A LITTLE LEAGUE FUNCTION, PRACTICE OR GAME.

Complete the form and send it to the Safety Officer:

Upper Division – Reagan Berkley
Reagan.Berkley@gmail.com

Lower Division – Reagan Berkley
Reagan.Berkley@gmail.com

Costa Mesa Little League

"I will always do my best"

Activities/Reporting

A Safety Awareness Program's Incident/Injury Tracking Report

League Name: _____ League ID: ___ - ___ - ___ Incident Date: _____

Field Name/Location: _____ Incident Time: _____

Injured Person's Name: _____ Date of Birth: _____

Address: _____ Age: _____ Sex: ❒ Male ❒ Female

City: _____ State _____ ZIP: _____ Home Phone: ( ) _____

Parent's Name (If Player): _____ Work Phone: ( ) _____

Parents' Address (If Different): _____ City _____

Incident occurred while participating in:

A.) ❒ Baseball ❒ Softball ❒ Challenger ❒ TAD

B.) ❒ Challenger ❒ T-Ball (5-8) ❒ Minor (7-12) ❒ Major (9-12) ❒ Junior (13-14)
❒ Senior (14-16) ❒ Big League (16-18)

C.) ❒ Tryout ❒ Practice ❒ Game ❒ Tournament ❒ Special Event
❒ Travel to ❒ Travel from ❒ Other (Describe): _____

Position/Role of person(s) involved in incident:

D.) ❒ Batter ❒ Baserunner ❒ Pitcher ❒ Catcher ❒ First Base ❒ Second
❒ Third ❒ Short Stop ❒ Left Field ❒ Center Field ❒ Right Field ❒ Dugout
❒ Umpire ❒ Coach/Manager ❒ Spectator ❒ Volunteer ❒ Other: _____

Type of injury: _____

Was first aid required? ❒ Yes ❒ No If yes, what: _____

Was professional medical treatment required? ❒ Yes ❒ No If yes, what: _____
(If yes, the player must present a non-restrictive medical release prior to to being allowed in a game or practice.)

Type of incident and location:

A.) On Primary Playing Field
❒ Base Path: ❒ Running *or* ❒ Sliding
❒ Hit by Ball: ❒ Pitched *or* ❒ Thrown *or* ❒ Batted
❒ Collision with: ❒ Player *or* ❒ Structure
❒ Grounds Defect
❒ Other: _____

B.) Adjacent to Playing Field
❒ Seating Area
❒ Parking Area

C.) Concession Area
❒ Volunteer Worker
❒ Customer/Bystander

D.) Off Ball Field
❒ Travel:
❒ Car *or* ❒ Bike *or*
❒ Walking
❒ League Activity
❒ Other: _____

Please give a short description of incident: _____

Could this accident have been avoided? How: _____

This form is for Little League purposes only, to report safety hazards, unsafe practices and/or to contribute positive ideas in order to improve league safety. When an accident occurs, obtain as much information as possible. For all claims or injuries which could become claims, please fill out and turn in the official Little League Baseball Accident Notification Form available from your league president and send to Little League Headquarters in Williamsport (Attention: Dan Kirby, Risk Management Department). Also, provide your District Safety Officer with a copy for District files. All personal injuries should be reported to Williamsport as soon as possible.

Prepared By/Position: _____ Phone Number: (_____) _____

Signature: _____ Date: _____

Warm-Up Drills

The subject of warming up before a practice session has been covered as a means of safeguarding youngsters, at least to a degree, from poor physical condition and lack of limbering up. Use of the term "warming-up drills," in connection with unsafe acts, refers to ball handling practice rather than calisthenics. This involves a serious accident exposure to misdirected balls. The following will reduce the danger of being struck by a misdirected ball:

1. All unauthorized people should remain off the field during drills.

2. After the number of targets has been reduced to minimum, one of the best preventive measures is to stress that the eye must be kept on the ball. This safe practice should be drilled into both adults and youngsters so continuously that it becomes a reflex action. 3. Another danger from misdirected balls is the exposure of inexperienced batters to wild pitchers. The use of batter's helmets is a must. However, it does not justify permitting a potential pitcher throwing to an inexperienced batter until control is demonstrated.

3. The danger of being struck by a ball can be further minimized by the following plan:

    a) Throwing and catching drills should be set up with players in two lines facing one another.
    b) Random throwing should be permitted only to designated players.

Safe Ball Handling

1. Misjudging the flight of a batted ball may be corrected by drilling with fly balls that begin easy and made more difficult as a player's judgment and skill improves. Everyone should eventually be able to handle balls that go overhead.

2. In addition to a player never losing sight of a ball from the time it leaves the bat, the player should keep the glove positioned and the body relaxed for a last split-second move.

3. An infielder can best be protected by an aggressive short-hop fielding play by always keeping the "nose pointed at the ball" and the eyes glued on it. Also, if moving forward, the player is in a better position to make a throw.

4. It is safer for the player to knock a ball down and rehandle it then to let the ball determine the play.

Collisions

Collisions result in more injuries than is the case with most other types of accidents. They are usually caused by errors of judgment or lack of teamwork between fielders. It is important to establish zones of defense to avoid collisions between players. It is particularly important when players are chasing high fly balls. Once the zones are established, play situation drills should be held until these zones and patterns become familiar to the players. The responsible player should call out the intentions in a loud voice to warn others away. Here are some general rules to follow:

1. The fielder at third base should catch all balls which are reachable and are hit between third and the catcher.

2. The fielder at first base should catch all balls reachable which are hit between second and the catcher.

3. The shortstop should call all balls reachable which are hit behind third base.

4. The fielder at second base should catch all balls reachable which are hit behind first base.

5. The shortstop has the responsibility for fly balls hit in the center of the diamond and in the area of second base. Since the glove is on the left hand it is easier for the shortstop than the fielder at second to catch fly balls over second base.

6. The centerfielder has the right of way in the outfield and should catch all balls which are reachable. Another player should take the ball if it is seen that it is not reachable by the centerfielder.

7. Outfielders should have priority over infielders for fly balls hit between them.

8. Priorities are not so easy to establish on ground balls, but most managers expect their base player to field all ground balls they can reach, cutting in front of the shortstop on slow hit grounders.

9. The catcher is expected to field all topped and bunted balls, which can be reached except when there is a force play or squeeze play at home plate.

Retrieving Ball

Balls that go out of the park should be retrieved by persons who have been specifically assigned to that duty. Such persons should be youngsters who can be relied on not to endanger themselves by climbing fences or getting into a scramble for possession of a ball.

Keep Grounds Clear

Another duty that should be given in turn to alert substitute players is the picking up of bats and proper placement in the rack. The clearing up of other loose playing equipment should be included in this assignment.

Sliding Safety

As is the case with other baseball fundamentals, a correct slide is also a safe one. It is well, too, to guard against the accident of a collision and the possibility of a player being struck by a thrown ball as that player "hits the dirt." It goes without saying that steel spikes are not being worn. The following can make the learning period safer:

1. Long grass has been found to be better than a sand or sawdust pit to teach sliding.

2. The base must not be anchored down.

3. Sliding pads are recommended.

4. The player should make approaches at half speed and keep constantly in mind that hands and feet should be in the air. Once committed to slide, the player must not change strategy. Last minute hesitation causes most sliding injuries.

5. Tennis shoes are suggested for beginning sliding and tagging practice to avoid injury to the defensive player.

6. If the ground along the baselines becomes soft on a rainy day, such weather offers an excellent opportunity to have sliding drills.

7. It should be kept in mind that head-first sliding is not recommended except when returning to a base. Head-first sliding has been eliminated for ages 12 and below, except for when returning to base.

Batter Safety

A batter's greatest accident exposure is from the unsafe acts of others, namely wild pitches, which account for a major portion of all accidents. Again, the best defense is an alert, confident concentration on the ball. This type of injury is more prevalent in Regular than in Minor League play. Since the danger is increased as pitchers learn to throw with greater force and as more games are played, it is doubly important to take whatever counter measures necessary to offset this exposure.

1. A well-fitted, NOCSAE approved helmet is the first requirement.

2. The development of the novice batter's ability to take evasive action can be improved by getting the player to relax and concentrate on the ball from the time the pitcher starts delivery until it lands in the catcher's mitt. Players with slow reflexes can also be helped by stimulated batting and ducking practice with a tennis ball.

3. The unsportsmanlike practice of crowding the plate or jumping around to rattle the pitcher must not be tolerated. This could endanger the batter if it causes the pitcher to lose control. Umpires should stop such actions.

4. Painful finger and hand injuries can be reduced by making sure the batter holds the bat correctly when bunting. Youngsters have a tendency to lean too far over the plate and not keep the ball well out toward the end of the bat. This should be corrected.

5. When the batter becomes a base runner, that player should be taught to run outside the foul lines when going from home plate to first and from third to home, to reduce the chance of being hit by a thrown ball.

Safe Handling of Bats

A review of the batter's potential for causing injuries to others brings up the following:

1. The most easily prevented type of accident is the too frequent fault of beginners throwing the bat while running to first base. This unthinking act may be corrected through individual instruction to drop the bat safely by:

(a) Having the player hand the bat to the coach will serve as a reminder before each ball is pitched.

(b) Having the player drop the bat in a marked-off circle near where running starts.

(c) Counting the player "out" in practice whenever the player fails to drop the bat correctly.

(d) Providing bats with grips that are not slippery.

2. Coaches and umpires should be on the alert to correct batters that have a tendency to step into the catcher as they swing.

A Dangerous Weapon

We use this heading to note the seriousness of an accident exposure that may sound impossible but one which has caused several very serious accidents on numerous occasions. Serious injury is waiting for the absent-minded youngster who unknowingly walks into the swing of the coach's bat when the coach is hitting flies, or the equally unwary player who walks into another players swing. These situations demonstrate the need for everyone to become safety-minded, not only for their own good but also for the safety of others. It is a good idea to have the player assigned to catch balls for the coach hitting flies, to be given the specific assignment of warning away anyone who comes too close

Catcher Safety

1. The catcher, as might be expected from the amount of action involved has the potential for more accidents than any other player. Assuming the catcher is wearing the required protection the greatest exposure is to the ungloved hand. The catcher must learn to:

(a) Keep it relaxed.

(b) Always have the back of the throwing hand toward the pitcher when in position to catch.

(c) Hold all fingers in a cupped position near the mitt, ready to trap the ball and throw it.

2. The catcher should also be taught to throw the mask and catcher's helmet in the direction opposite the approach in going for a high fly.

3. As the catcher learns to play this difficult position, a good habit is to keep a safe distance back from the swinging bat. Estimate this as one foot farther from the batter than the ends of the outstretched fingers.

4. To repeat, the best protection is keeping the eye on the ball.

General Inattention

Going one step back to the "whys" of most ball handling accidents, it appears that inattention due to inaction or boredom is an underlying accident cause with which we must deal. This situation can be partly offset by using idle time to practice basics of skillful and safe play, such as:

1. Otherwise idle fielders should be encouraged to "talk it up." Plenty of chatter encourages hustle and enthusiasm.

2. Players waiting for a game or practice to start can pair off and play catch to improve their basic eye-on-the ball technique.

3. Practice should include plenty of variety in the drill work.

4. Put a time limit on each drill and do not hold the total practice for more than two hours or less if interest begins to lag.

5. Idle players along the sidelines can be given the job of studying the form of other players to improve their own techniques. They may then report on what they have learned to improve their own form on running, ball handling, throwing, batting and sliding.

Control of Horseplay

No discussion of measures to control the human element in accident-prevention would be complete without going into the problem of horseplay. This includes any type of youthful hijinks that could even remotely be the cause of an accident. Even a mild form of such behavior could distract a player about to catch a ball or possibly when at bat, and result in an accident. After all—team play requires 100% cooperation among all players, and good sportsmanship demands courtesy to opposing players. If individuals cannot find appropriate and sufficient outlet for their high spirits in the game, quick and impartial discipline should be used to address the issue.

FIRST AID

First aid is an important protection that must be available in case of an emergency involving any injury.

Definition
First aid is the immediate, necessary, temporary, emergency care given for injuries.

Selection and Qualifications of First Aiders:
It is recognized as impractical to have a completely trained and experienced first aider on duty at all times. However, every effort should be made to have several alternate first aiders, preferably adults whose duties keep them at the field, trained in the basic requirements of first aid treatment.
Ideally, this training should be from an accredited agency such as the American Red Cross. The alternative is to have them trained briefly and specifically for this purpose by a medical doctor or a registered nurse who is familiar with Little League operations. Minimum first aid training should include the handling of extreme emergencies such as the usage of mouth-to-mouth resuscitation and external cardiac massage.

First Aid Equipment

Since this section is not intended as a First Aid Manual, we have omitted information on treatment. Both this and the proper equipping of the first aid kit should be left to the advice of local medical authorities. It is suggested, however, that in addition to the stock of bandages, the following be available:

1. A supply of clean water, soap and towels
2. A blanket
3. Arm and leg splints
4. Easily accessible phone with emergency phone numbers, such as doctor, hospital and ambulance service.

CMLL TRAUMA KIT LOCATED IN MANAGER'S SHED at old CMALL site and in the Snack Bar of the old CMNLL site

Notification of Family

It is extremely important that, as soon as provision has been made for the care of injured or ill people who require outside treatment their family be notified in as tactful a manner as possible.

Follow-Up on First Aid Cases

Care of an ill or injured individual must always be the first consideration. In concern for their welfare, however, do not neglect the following:

1. A thorough investigation should be made to find the cause(s) of an accident and action started to prevent reoccurrence.

2. An insurance claim should be filed when outside medical attention is required. Do not wait for medical bills to arrive. They can be submitted as they become available. They must be identified by including the person's name, league name and number, date of injury, and city and state of residence. Bills should be itemized to show dates and type of treatments.

3. Any player under the care of a doctor should be required to bring a note from the doctor to the manager releasing the player to play ball before being allowed to return to the lineup.

PUBLIC LIABILITY

The responsibility of all organizations and their individual members for the safety of the general public has become an increasingly important factor in present-day society.

Little League's Obligation
As a non-profit organization supported by public funds and operated by volunteers we should have a deep interest in the safety of the general public as well as the protection of our Little League volunteers from lawsuits. Even though we cannot fully protect the public from all situations arising out of the operation of a league, we can safeguard them from our own unintentional negligence.

Consequences of Being Sued

No matter how unjustified a liability suit may be, we should be concerned about the effects of such legal action on Little League and particularly on the men and women who make the league possible.

1. The worst result of such a suit, if there is no liability insurance coverage, is the possibility of wrecking the financial position of the individual against whom the suit is directed. In cases where a large judgment is obtained against an individual, the Court may take over all of a Person's assets and even attach future earnings for years to come.

2. Another ill effect is unfavorable publicity from news releases, which are sometimes of a sensational nature. They can damage the public good will which has taken years to build.

Protective Measures

1. Obviously our best protection against the relentless attacks of a few claim-minded individuals is to have adequate liability insurance coverage from a reputable company. This will protect local league officials but not the good name of the league and its members.

2. Some legal protection can be obtained by incorporating a league under the laws of the state in which it operates. This is not to be confused with Little League Baseball, Incorporated, which cannot pass the advantages of its incorporation on to individual Little Leagues. They must be incorporated under the laws of the state in which they operate.

This relatively inexpensive protection will safeguard the league as a whole and its members, to a degree, from unlimited financial responsibility for a judgment against the league. However, it will not relieve anyone from the legal expenses required to defend against a suit, nor will it limit the legal responsibility of persons who may be sued as individuals. A league desiring to use the words "Little League" in its corporate title must first obtain consent from Little League Headquarters.

3. As in the case of player accidents, we can go a long way toward safeguarding the good name of Little League and the best interests of all individuals by taking a few common-sense precautions.

Avoid Negligence

The taking of precautions should be based on this main objective of avoiding any implication of negligence on the part of Little League people. In most successful public liability suits, the claimant must prove that some organization or individuals have been negligent in their obligation to safeguard the general public.

Costa Mesa Little League

"I will always do my best"

Weather Procedures

No activities of any kind will be permitted on fields closed by weather conditions. Any team, manager or coach who willingly attempts to play or practice on any closed field will be subject to disciplinary action by the CMLL Board of Directors. Please call Mudline @ (714) 754-5041

Lightning Facts and Safety Procedures

Consider the following facts:

The average lightning stroke is 6-8 miles long

The average thunderstorm is 6-10 miles wide and travels at a rate of 25 miles per hour Once the leading edge of a thunderstorm approaches to within 10 miles, you are at immediate risk due to the possibility of lightning strokes coming from the storm's overhanging anvil cloud (for example, the lightning that injured 13 people during a concert several years ago occurred while it was sunny and dry).

One the average, thunder can only be heard over a distance of 3-4 miles, depending on humidity, terrain and other factors. This means that by the time you hear the thunder, you are already in the risk area for lightning strikes.

"Flash-Bang" Method

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

Rule of Thumb

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

When in doubt, the following rule of thumb should be applied: Where to Go?

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

Where NOT to Go!

Avoid high places and open fields, isolated trees, unprotected gazebos, rain or picnic shelters, dugouts, flagpoles, light poles, bleachers (metal or wood), metal fences and water- also avoid mower shed and snack bar- use only as last resort.

CPR and First Aid Message from a Past President

Everyone gets involved in coaching Little League for their own reasons. When I started coaching Little League a number of years ago I wanted to have practices on my schedule. I was interested in the coaching clinics for the first few times but they became repetitive very quickly. I resented learning about first aid and CPR every year. What a waste of time, or so I thought.

A few years ago 30 minutes before game time a boy I know came running to me asking for help with his father. He said his dad fell and was not moving. We both ran over to his location and I found his father unconscious and barely breathing. Soon after another adult showed up and dialed 9-1-1. Within a few minutes the man's heart stopped and he stopped breathing. An off-duty police officer jumped in and asked if anyone knew CPR that could help him. Not a single other coach or parent around could help. We performed CPR until the paramedics arrived and stabilized him. Today he is alive and able to still enjoy watching his son play Little League. Today his son is still able to enjoy playing baseball instead of knowing that he lost his father on the Little League field. It took less than 15 minutes for the paramedics and fire department to respond, but those were the longest 15 minutes I have ever experienced.

Please take a look at the kids on your team. Which child will you tell this year that one of their parents, grandparents, brother, or sister just died on the Little League field because no one knew CPR and first aid? I'm sure they will understand that you skipped the training because your favorite show was on TV that night. Who will be there if your child gets hurt?

As a parent I am thankful that so many managers and coaches take the time to be serious about first aid and CPR. Each and every one of the kids involved in our league are precious and wonderful gifts, but, my own children are out there too. I am out there too. I know that if anything happens to me or my children someone will step up and help out. Heart attacks, strokes, and other ailments do not only affect the elderly. The man in this story was not even 35 years old.

Yes, I did attend the CPR clinic that year, and I have not missed one since.

Sincerely,

Jared Johnson

Costa Mesa American Little League

CONCUSSION INFORMATION SHEET

HEADS UP CONCUSSION

This sheet has information to help protect your children or teens from concussion or other serious brain injury. Use this information at your children's or teens' games and practices to learn how to spot a concussion and what to do if a concussion occurs.

WHAT IS A CONCUSSION?

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

[INSERT

HOW CAN I SPOT A POSSIBLE CONCUSSION?

Children and teens who show or report one or more of the signs and symptoms listed below—or simply say they just "don't feel right" after a bump, blow, or jolt to the head or body—may have a concussion or other serious brain injury.

SIGNS OBSERVED BY PARENTS OR COACHES

- Appears dazed or stunned.
- Forgets an instruction, is confused about an assignment or position, or is unsure of the game, score, or opponent.
- Moves clumsily.
- Answers questions slowly.
- Loses consciousness (even briefly).
- Shows mood, behavior, or personality changes.
- Can't recall events prior to or after a hit or fall.

SYMPTOMS REPORTED BY CHILDREN AND TEENS

- Headache or "pressure" in head.
- Nausea or vomiting.
- Balance problems or dizziness, or double or blurry vision.
- Bothered by light or noise.
- Feeling sluggish, hazy, foggy, or groggy.

- Just not "feeling right," or "feeling down."

WHAT ARE SOME MORE SERIOUS DANGER SIGNS TO LOOK OUT FOR?

In rare cases, a dangerous collection of blood (hematoma) may form on the brain after a bump, blow, or jolt to the head or body and can squeeze the brain against the skull. Call 9-1-1 or take your child or teen to the emergency department right away if, after a bump, blow, or jolt to the head or body, he or she has one or more of these danger signs:

- One pupil larger than the other.
- Drowsiness or inability to wake up.
- A headache that gets worse and does not go away.
- Slurred speech, weakness, numbness, or decreased coordination.
- Repeated vomiting or nausea, convulsions or
-

As a parent, if you think your child or teen may have a concussion, you should:

1. Remove your child or teen from play.
2. Keep your child or teen out of play the day of the injury. Your child or teen should be seen by a health care provider and only return to play with permission from a health care provider who is experienced in evaluating for concussion.
3. Ask your child's or teen's health care provider for written instructions on helping your child or teen return to school. You can give the instructions to your child's or teen's school nurse and teacher(s) and return-to-play instructions to the coach and/or athletic trainer.

Do not try to judge the severity of the injury yourself. Only a health care provider should assess a child or teen for a possible concussion. Concussion signs and symptoms often show up soon after the injury. But you may not know how serious the concussion is at first, and some symptoms may not show up for hours or days.

The brain needs time to heal after a concussion. A child's or teen's return to school and sports should be a gradual process that is carefully managed and monitored by a health care provider.

- Unusual behavior, increased confusion, restlessness, or agitation.
- Loss of consciousness (passed out/knocked out). Even a brief loss of consciousness should be taken seriously.

WHAT SHOULD I DO IF MY CHILD OR TEEN HAS A POSSIBLE CONCUSSION?

HOW CAN I HELP KEEP MY CHILDREN OR TEENS SAFE?

Sports are a great way for children and teens to stay healthy and can help them do well in school. To help lower your children's or teens' chances of getting a concussion or other serious brain injury, you should:

- Help create a culture of safety for the team.
  - ›› Work with their coach to teach ways to lower the chances of getting a concussion.

HEADS UP CONCUSSION

[INSERT YOUR LOGO]

TO LEARN MORE GO TO >> cdc.gov/HEADSUP

›› **Talk with your children or teens about concussion and ask if they have concerns about reporting a concussion. Talk with them about their concerns; emphasize the importance of reporting concussions and taking time to recover from one.**

›› **Ensure that they follow their coach's rules for safety and the rules of the sport.**

››

TTell your children or teens that you expect them to practice good sportsmanship at all times.

- **When appropriate for the sport or activity, teach your children or teens that they must wear a helmet to lower the chances of the most serious types of brain or head injury. However, there is no "concussionproof" helmet. So, even with a helmet, it is important for children and teens to avoid hits to the head.**

JOIN THE CONVERSATION AT www.facebook.com/CDCHEADSUP

Content Source: CDC's HEADS UP campaign. Customizable HEADS UP fact sheets were made possible through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

Only a player on the field and at bat may swing a bat (Age 5 - 12).

Observe all posted signs. Players and spectators should be Alert at all times for Foul Balls and Errant Throws.

During game, players must remain in the dugout area in an orderly fashion at all times.

After each game, each team must clean up trash in dugout and around stands.

All gates to the field must remain closed at all times. After players have entered or left the playing field, gates should be closed and secured.

No children under the age of 14 are to be permitted in the Snack Bars Failure to comply with the above may result in expulsion from the Costa Mesa Little League field or complex.

Keep It Clean: Concession Stand Tips

12 Steps to Safe and Sanitary Food Service Events

The following information is intended to help you run a healthful concession stand. Following these simple guide-lines will help minimize the risk of food borne illness. This information was provided by Costa Mesa Little League, and is excerpted from "Food Safety Hints" by the Orange County Department of Health.

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

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

3. Reheating. Rapidly reheat potentially hazardous foods to 165º F. Do not holding devices. Slow-cooking mechanisms may activate bacteria and never reach killing temperatures.

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

5. Hand Washing. Frequent and thorough hand washing remains the first line of defense in preventing food borne disease. The use of disposable

gloves can provide an additional barrier to contamination, but they are no substitute for hand washing!

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

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

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

I. Washing in hot soapy water;
II. Rinsing in clean water; III. Chemical or heat sanitizing; and IV. Air drying.

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

10. Wiping Cloths. Rinse and store your wiping cloths in a bucket of sanitizer (example: 1 gallon of water and 1/2 teaspoon of chlorine bleach). Change the solution every two hours. Well sanitized work surfaces prevent cross-contamination and discourage flies.

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

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

Top Six Causes

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

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

Clean Hands for Clean Foods

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

- Use soap and warm water.
- Rub your hands vigorously as you wash them.
- Wash all surfaces including the backs of hands, wrists, between fingers and under fingernails.
- Rinse your hands well.
- Dry hands with a paper towel.
- Turn off the water using a paper towel, instead of your bare hands.
- Wash your hands in this fashion before you begin work and frequently during the day, especially after performing any of these activities:

    - After touching bare human body parts other than clean hands and clean, exposed portions of arms. o 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. o After drinking, using tobacco, or eating.
    - During food preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks.
    - When switching between working with raw food and working with ready-to-eat food.
    - Directly before touching ready-to-eat food or food-contact surfaces.
    - After engaging in activities that contaminate hands

Hot Day Guidelines

Before:
Drink 8 oz. immediately before exercise

During:
Drink at least 4 oz. every 20 minutes

After:
Drink 16 oz. for every pound of weight lost

Dehydration signs:
Fatigue, flushed skin, light-headed

What to do:
Stop exercising; get out of sun, drink

Severe signs:
Muscle spasms, clumsiness, delirium

CMLL FIRST AID GUIDE

League Trauma Kit can be found in the manager's shed or the snack bar if at the old Costa Mesa National Fields

First aid: treating common sports injuries

A guide to common sports injury and common treatments A look at bones, joints and pain

Face it... at one time or another, all sports can cause some form of injury. Whether it's a sprained ankle while out golfing or a broken arm from a bad tackle in football, knowing how to treat these injuries can be a great asset to any player or watcher of almost any sport. Of course, there are some injuries that require immediate medical attention; should one of these injuries occur, don't hesitate to make that trip to the doctor's office or the emergency room. Below is a list of common injuries as well as their treatments. Take note if medical attention is recommended; it can make all of the difference.

Bruises: Given enough time, bruises will happen in 99% of sports. Usually, they're nothing to worry about... they're busted vessels in the skin, and the blood will diffuse and the bruise will fade in a few days. You can speed up the process by applying heat or commercially available creams to the area. Should the bruise darken or spread after several days, or red lines or additional irritation appear, visit a doctor in case infection or blood poisoning has begun to set in.

Scrapes: Another common injury, scrapes and abrasions usually look worse than they are. They don't usually bleed too much, but can be quite painful for a few days. Clean the wound and apply a topical cream, then wait for it to scab over. Should additional redness or irritation occur after a few days, have a doctor look at it in case of infection.

Sprains and Strains: A SPRAIN is an abnormal stretching or tearing of a ligament that supports a joint. A STRAIN is abnormal stretching or tearing of a muscle or tendon. Both may be caused by a single injury or repetitive activities. RICE: Rest, Ice, Compression, Elevation are keys to the initial treatment. Most Sprains and Strains resolve on their own with conservative treatment, but based on the severity of the injury may need to be seen by an Orthopedic Specialist. The severity of the Sprain/Strain can be categorized into three levels. Grade 1 strains/sprains usually cause stretching of a few of the ligament or muscle fibers. Grade 2 strains/sprains have more significant damage, and some muscle/ligament fibers are damaged or torn. Grade 3 strain/sprain is a complete rupture or tear of tendon or ligament. The initial severity of swelling and discoloration is a good indicator of the grade of the sprain/strain.

Overuse Injuries: There has been a sharp increase in the incidence of shoulder and elbow injuries, especially in young baseball players which is an alarming trend. This has been directly correlated to the increase in the "one sport athlete" with year round, single sport-specific training and has been most obvious in baseball players. The vast majority of injuries are due to overuse and overtraining, and therefore can be avoided. With proper stretching and appropriately moderated training, young athletes can significantly limit their risk of overuse injury.

- Warm Up Properly: stretch, run, and gradually ease into throwing.
- Follow Age-Appropriate Guidelines: develop skills appropriate for your age level, and follow Little League Baseball pitch count guidelines.
- Don't Play Through The Pain: avoid pitching if you have elbow or shoulder pain, and communicate your symptoms to coaches, parents, and sports medicine professionals.
- Practice Moderation: don't pitch on consecutive days or on multiple teams during a season, and avoid playing year round.
- Signs and Symptoms of Overuse Injuries: It is very important to know what to look for in order to limit the risk of overuse injuries.

    -Elbow or Shoulder pain the day after throwing.

    -Movement that is painful or restricted, especially compared to the opposite arm.

    -Swelling in the Joint.

If a player complains of any of the above symptoms, the appropriate steps would be to shut him/her down on throwing activities and recommend the parents to seek a sports medicine physician. Early intervention can help prevent such injuries from getting worse.

Cuts/Punctures: Cuts and punctures in sports most often occur when a piece of sports equipment breaks the skin. The severity of the injury can vary from minor to extreme, but should always be checked for additional damage below the skin. Very minor cuts require very little care at all other than cleaning and bandaging, but any cut or puncture with even moderate bleeding needs medical attention. In case of heavy bleeding, apply pressure to the wound with a clean dry cloth until help can arrive. Large wounds, even if they do not bleed an extreme amount, still should be taken to a doctor in case stitches are needed. Punctures, even very small ones, should be watched for a while because they tend to get infected easier than larger wounds.

Breaks: Broken bones are a serious matter. Unless properly set, the bone can heal incorrectly, and can also cause further internal injury. In the event of a broken bone or even a suspected broken bone, the victim should be taken to a doctor or hospital immediately for treatment. Hopefully, all of your sports experiences will be safe ones, but should the worst happen, you may as well be prepared with the knowledge of what to do.

The R.I.C.E. Method of Acute Injury Treatment

Rest: Resting is important immediately after injury for two reasons. First, rest is vital to protect the injured muscle, tendon, ligament or other tissue from further injury. Second, your body needs to rest so it has the energy it needs to heal itself most effectively.
Ice: Use ice bags, cold packs or even a bag of frozen peas wrapped in a thin towel to provide cold to the injured area. Cold can provide short-term pain relief. It also limits swelling by reducing blood flow to the injured area. Keep in mind, though, that you should never leave ice on an injury for more than 15-20 minutes at a time. Longer exposure can damage your skin. The best rule is to apply cold compresses for 15 minutes and then leave them off for at least 20 minutes. (Read The Proper Use of ICE).
Compression: Compression helps limit and reduce swelling, which slows down healing. Some people also experience pain relief from compression. An easy way to compress the area of the injury is to wrap an ACE bandage around the swollen part. If you feel throbbing, or if the wrap just feels too tight, remove the bandage and re-wrap the area so the bandage is a little looser.
Elevation: Elevating an injury reduces swelling. It's most effective when the injured area is raised above the level of the heart. For example, if you injure an ankle, try lying on your bed with your foot propped on one or two pillows.

After a day or two of R.I.C.E., many sprains, strains or other injuries will begin to heal. But if your pain or swelling does not decrease after 48 hours, make an appointment to see your primary care physician or go to the emergency room, depending upon the severity of your symptoms. Once the healing process has begun, very light massage may improve the function of forming scar tissue, cut healing time and reduce the possibility of injury recurrence.

Gentle stretching can be begun once all swelling has subsided. Try to work the entire range of motion of the injured joint or muscle, but be extremely careful not to force a stretch, or you risk re-injury to the area. Keep in mind that a stretch should never cause pain. For proper stretching technique, review FlexibilityExercises.

Heat may be helpful once the injury moves out of the acute phase and swelling and bleeding has stopped. Moist heat will increase blood supply to the damaged area and promote healing. Finally, after the injury has healed, strengthening exercises can be begun. Start with easy weights and use good form.

How to Recognize and Treat a Broken Arm or Leg

Broken arms are very painful injuries and rarely life-threatening emergencies. Learn to recognize a broken arm to decide how to respond to it.

Signs and symptoms of a broken limb:

- Pain (almost always present)
- Swelling
- Bruising
- Deformity
- Broken skin with bone visible
- Limited mobility of the arm or leg

Here's How:

Safety First! Make sure the victim is in a safe location. It is more important to worry about rescuer and victim ongoing safety than to worry about one broken arm. Follow universal precautions and wear personal protective equipment if you have it.

Check ABC's. Make sure the victim has an Airway, is Breathing, and has Circulation. Broken arms can be very distracting injuries. Most of the time, however, they look worse than they are.

Control bleeding.

Look for other injuries. If a victim shows signs of injury to the head, neck or back, DO NOT move the victim.

Cover any broken skin with sterile dressings. If needed, the wound can be rinsed—try to use sterile water or saline solution.

If an ambulance is responding, have the victim remain still and wait for the ambulance. If an ambulance is unavailable, it may be necessary to splint the broken arm. Be sure to immobilize the joints (elbow, wrist, shoulder) above and below the break. Do not wrap the arm too tight. Put ice on the break to reduce swelling. Put a sheet or towel between the ice and the skin to prevent frostbite. Leave ice on for 15 minutes, then remove ice for 15 minutes.

Tips:

Remember, DO NOT move a victim with suspected head, neck, or back injuries unless it is to keep rescuers or victim safe.

DO NOT straighten a broken arm or change its position unless the victim's hand (on the arm with the break) is cold, blue, numb, or paralyzed. Only attempt to return a deformed arm to the anatomical position.

Call 911 for a leg broken above the knee, a broken hip, a broken pelvis, a neck or back injury, or a head injury. It is still acceptable to summon an ambulance for a broken arm, but call on the ambulance agency's non-emergency line. If splinting the broken arm, make a sling to support the arm's weight and wrap a swath around the victim's torso to immobilize the broken arm.

Treating a broken foot or wrist

If an ambulance is unavailable, it may be necessary to splint the broken foot. Before splinting, check circulation, sensation, and motion.

Check circulation by comparing the color and temperature of the injured foot against the uninjured foot.

Check sensation by asking the victim which toe you are touching.

Check motion by having the victim wiggle his or her toes.

To splint a broken foot, immobilize the foot with padding, such as a rolled up towel or a pillow. Be sure to immobilize the ankle as well. Any movement of the ankle will result in pressure on the foot. Do not wrap the foot too tight.

After splinting, recheck circulation, sensation, and motion.

Put ice on the break to reduce swelling. Put a sheet or towel between the ice and the skin to prevent frostbite. Leave ice on for 15 minutes, then remove ice for 15 minutes.

To splint a broken wrist, follow the steps for splinting a broken arm. Be sure to immobilize the hand. Any movement of the hand will result in pressure on the wrist. Do not wrap the wrist too tight.

After splinting, recheck circulation, sensation, and motion.

Put ice on the break to reduce swelling. Put a sheet or towel between the ice and the skin to prevent frostbite. Leave ice on for 15 minutes then remove ice for 15 minutes

Head Injury Recognition, First Aid for Skull Fracture & Closed Head Injury

Injuries to the head can cause damage to the skull, scalp, or brain. The brain rests inside the skull protected by a cushion of soft tissue called the meninges.

Skull Fracture

Head injuries typically come from blunt or penetrating trauma the head. The skull does not have to be fractured, but can be. If the skull is soft when touched, or missing, the victim has an open or depressed skull fracture. If skull fracture is suspected, call 911 immediately.

Other signs of a skull fracture include blood or clear fluid draining from the ears or nose, and bruising around both eyes or behind the ears.

Closed Head Injury

A closed head injury is an injury to the brain inside an intact skull. Injury to the brain causes swelling, which quickly increases the pressure within the skull (intracranial pressure). The increased pressure causes more damage to the brain, which causes more swelling, and so on. Common names for closed head injuries include:

□ concussion □ epidural hematoma □ subdural hematoma □ intracerebral hemorrhage □ increased intracranial pressure

Some types of closed head injury stop the cycle automatically (concussion), while others will continue to get worse until the victim dies (epidural hematoma). The only way to tell the difference is through a CT scan, which looks at the brain and the skull using xrays.

Signs and Symptoms of a Closed Head Injury

A victim struck with a blunt object should be watched for signs and symptoms of a closed head injury. If a victim of blunt head trauma has any of the following, call 911 immediately:

- loss of consciousness at the time of the injury (getting knocked out)
- short-term memory loss (victim keeps repeating questions)
- unable to wake the victim from sleeping
- confusion
- vomiting
- dizziness

- very high blood pressure
- very slow pulse
- Head Injury First Aid

In all cases of injury to the head and neck, it's vital not to move the victim's neck. Support his or her head in the position you found it. Bones of the spine (vertebra) can be injured from movement of the head during trauma. Broken or displaced spinal bones can cut or put pressure on the nerves of the spinal cord, causing temporary or permanent paralysis and loss of feeling.

Vomiting can lead to problems with the victim's airway. If the victim begins vomiting and is unconscious, place the victim in the recovery position to let the emesis (vomit) drain from the victim's mouth.

It is a myth that closed head injury victims should not be allowed to sleep. If a victim of trauma to the head does not have any of the signs or symptoms of closed head injury or skull fracture, there is no reason to keep him or her awake. Once asleep, wake the victim about 30 minutes after falling asleep to make sure he or she can be aroused. If you are unable to wake a victim of blunt head trauma 30 minutes after falling asleep, call 911 immediately.

CMLL Concussion Protocol

Concussions: A concussion is a type of traumatic brain injury that can have a serious effect on a young, developing brain. While most children and teens with a concussion recover quickly and fully, some will have concussion symptoms that last for days, weeks, or even months. Not giving the brain enough time to heal after a concussion can be dangerous. A repeat concussion that occurs before the brain heals from the first, usually within a short amount of time (hours, days, weeks), can slow recovery or increase the chances for long-term health problems. These may include changes in how the child thinks, feels, and acts, as well as their ability to learn and remember. While rare, a repeat concussion can result in brain swelling or permanent brain damage. It can even be fatal. (www.cdc.gov/concussion)

In an effort to protect our players, Costa American Little League utilizes a three step concussion policy. This policy includes educating our volunteers and families about concussions, removing the athlete from play when a concussion is suspected and obtaining medical permission for the athlete's return to play.

Education – On a yearly basis, the league will provide each family with concussion and head injury information. CMLL will request families acknowledge receipt of the educational materials in writing. Also, all managers will be required to complete yearly concussion training prior to supervising practices or games. Board members, assistant coaches, team parents and umpires shall also complete the yearly concussion training.

Removing the Player – If a player is suspected of sustaining a concussion or other head injury during practice or a game, the child must be immediately removed from the athletic activity for the remainder of the day. If a child is removed from athletic activity due to a suspected concussion, the team manager or other CMLL representative shall notify a parent or a guardian of that athlete, of the time of the injury, the symptoms observed and any treatment provided to the athlete for the injury.

Permission to Return to Play – If an athlete is removed from athletic activity by a CMLL representative, or if the child's team manager is made aware of the fact the athlete suffered a concussion unrelated to CMLL activities, the athlete shall not be permitted to return to athletic activity associated with CMLL until being evaluated by, and receiving written clearance to return to athletic activity from, a licensed health care provider. If it is determined by a licensed healthcare provider that the athlete sustained a concussion, the player shall be required to complete a graduated return to play protocol of not less than seven (7) days in duration under the supervision of a licensed health care provider.

Please visit www.cdc.gov/headsup for additional information.

CPR GUIDELINES

1. Attempt to wake victim. If the victim is not breathing (or is just gasping for breath), call 911 immediately and go to step 2. If someone else is there to help, one of you call 911 while the other moves on to step 2.

   If the victim is breathing, see the Tips section at the bottom of this page for what to do.

2. Begin chest compressions. If the victim is not breathing, place the heel of your hand in the middle of his chest. Put your other hand on top of the first with your fingers interlaced. Compress the chest at least 2 inches (4-5 cm). Allow the chest to completely recoil before the next compression. Compress the chest at a rate of at least 100 pushes but not more than 120 pushes per minute. Perform 30 compressions at this rate (should take you about 18 seconds).

   If you are not trained in CPR, continue to do chest compressions until help arrives or the victim wakes up.

   It's normal to feel pops and snaps when you first begin chest compressions - DON'T STOP! You're not going to make the victim worse.

3. Begin rescue breathing. If you have been trained in CPR, after 30 compressions, open the victim's airway using the head-tilt, chin-lift method. Pinch the victim's nose and make a seal over the victim's mouth with yours. Use a CPR mask if available. Give the victim a breath big enough to make the chest rise. Let the chest fall, then repeat the rescue breath once more. If the chest doesn't rise on the first breath, reposition the head and try again. Whether it works on the second try or

not, go to step 4. If you don't feel comfortable with this step, just continue to do chest compressions at a rate of at least 100/minute.

4. Repeat chest compressions. Do 30 more chest compressions just like you did the first time.
5. Repeat rescue breaths. Give 2 more breaths just like you did in step 3 (unless you're skipping the rescue breaths).
6. Keep going. Repeat steps 4 and 5 for about two minutes (about 5 cycles of 30 compressions and 2 rescue breaths).

   If you have access to an automated external defibrillator (AED), continue to do CPR until you can attach it to the victim and turn it on. If you saw the victim collapse, put the AED on right away. If not, attach it after approximately one minute of CPR (chest compressions and rescue breaths).

7. After 2 minutes of chest compressions and rescue breaths, stop compressions and recheck victim for breathing. If the victim is still not breathing, continue CPR starting with chest compressions.
8. Repeat the process, checking for breathing every 2 minutes (5 cycles or so), until help arrives. If the victim wakes up, you can stop CPR.

Tips:

1. Chest compressions are extremely important. If you are not comfortable giving rescue breaths, still perform chest compressions! It's called Hands Only CPR.
2. If the victim is breathing, briskly rub your knuckles against the victim's sternum. If the victim does not wake, call 911.
3. If the victim wakes up, but is confused or not able to speak, call 911.
4. This is not a substitute for actual CPR training. Find a CPR class and get proper training.

A-B-C is for babies; now it's C-A-B!

It used to be follow your ABC's: airway, breathing and chest compressions. Now, Compressions come first, only then do you focus on Airway and Breathing. The only exception to the rule will be newborn babies, but everyone else -- whether it's infant CPR, child CPR or adult CPR -- will get chest compressions before you worry about the airway.

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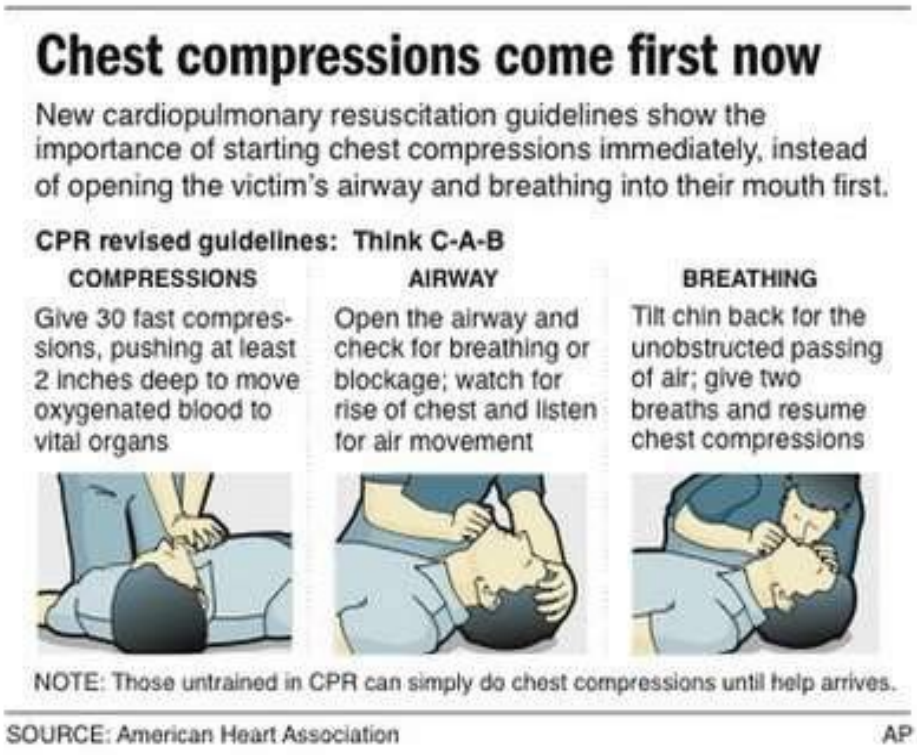


Chest compressions come first now

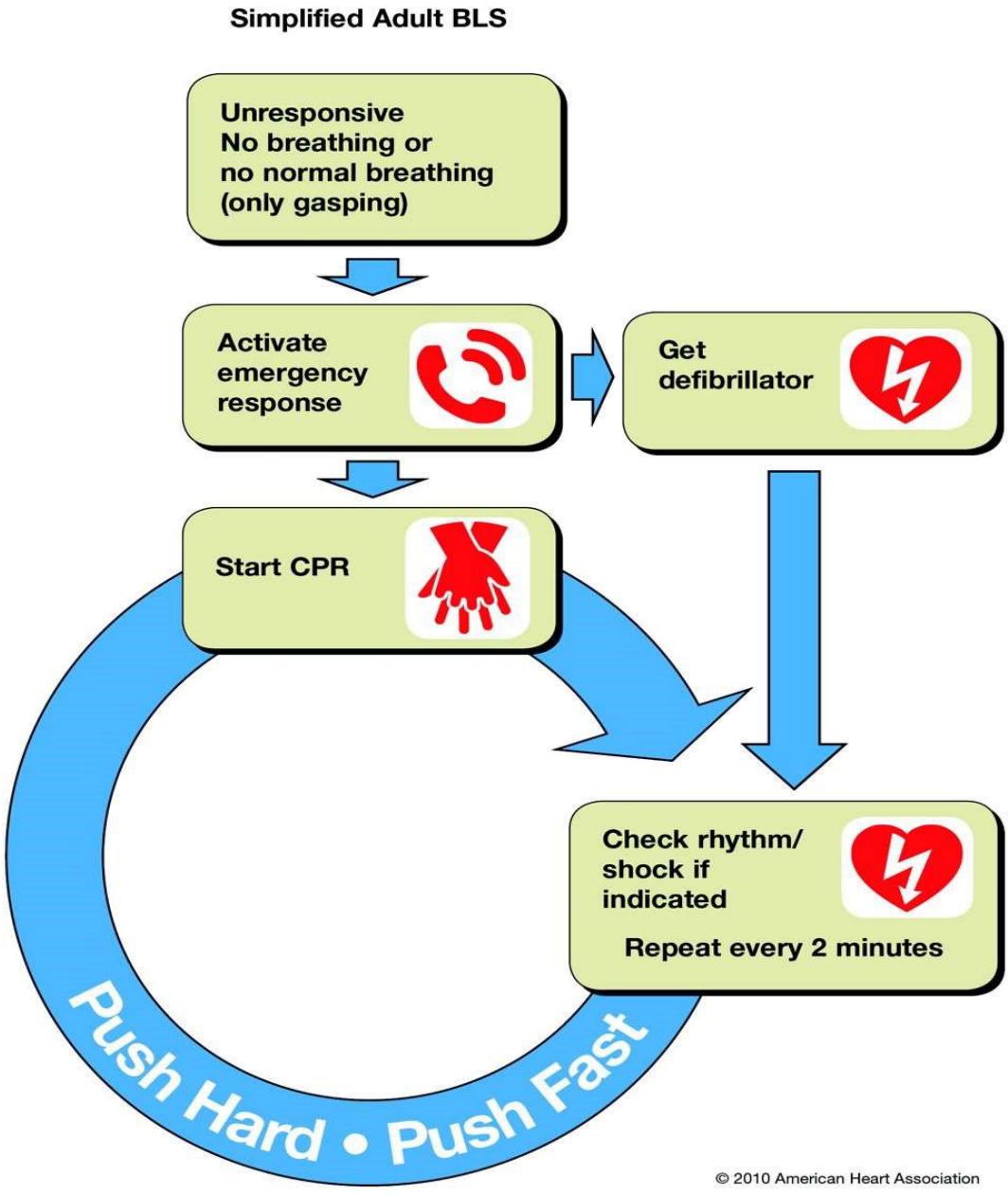
New cardiopulmonary resuscitation guidelines show the importance of starting chest compressions immediately, instead of opening the victim's airway and breathing into their mouth first.

CPR revised guidelines: Think C-A-B

COMPRESSIONS	AIRWAY	BREATHING
Give 30 fast compressions, pushing at least 2 inches deep to move oxygenated blood to vital organs	Open the airway and check for breathing or blockage; watch for rise of chest and listen for air movement	Tilt chin back for the unobstructed passing of air; give two breaths and resume chest compressions

NOTE: Those untrained in CPR can simply do chest compressions until help arrives.

SOURCE: American Heart Association AP


Simplified Adult BLS
Unresponsive
No breathing or
no normal breathing
(only gasping)
Activate
emergency
response
Get
defibrillator
Start CPR
Check rhythm/
shock if
indicated
Repeat every 2 minutes
Push Hard • Push Fast
© 2010 American Heart Association

Question: Why did CPR change from A-B-C to C-A-B?

The 2010 CPR Guidelines rearranged the order of CPR steps. Now, instead of A-B-C, which stands for airway and breathing first followed by chest compressions, the American Heart Association wants rescuers to practice C-A-B: chest compressions first, then airway and breathing. Some have asked, why did CPR change?

Answer: Just like you can hold your breath for a minute or two without having brain damage, victims of cardiac arrest can go a minute or two (actually a lot longer than that) without taking a breath. What cardiac arrest victims really need is for that blood to get flowing again.

When rescuers are worried about opening the airway and making an adequate seal, plus the "ick" factor and possibly digging a CPR mask out of a purse or briefcase, the delay can be significant. All that extra time is getting in the way of real help: Chest compressions.

In its summary of the changes, the American Heart Association explained it this way:

In the A-B-C sequence chest compressions are often delayed while the responder opens the airway to give mouth-to-mouth breaths or retrieves a barrier device or other ventilation equipment. By changing the sequence to C-A-B, chest compressions will be initiated sooner and ventilation only minimally delayed until completion of the first cycle of chest compressions (30 compressions should be accomplished in approximately 18 seconds).

So as you can see, by starting chest compressions first, the victim only has to hold his breath an extra 18 seconds while blood gets flowing again. In my opinion, that's a good trade.

Costa Mesa Little League, CMLL Fields Automated External Defibrillation Program

1. Scope

En-Pro Management, Inc. is dedicated to establishing, maintaining and overseeing a successful Automated External Defibrillation (AED) Program for Costa Mesa Little League. En-Pro Management, Inc.'s support specialist will work with employees and volunteers to serve as trained responders in the event of a medical emergency requiring cardiopulmonary resuscitation (CPR) and the use of an AED. This document describes the guidelines.

2. Purpose

The purpose of this document is to establish effective, comprehensive, and consistent guidelines. These guidelines will apply to the site assessment, application, maintenance, training and other components that may be required by Costa Mesa Little League so that En-Pro can ensure that an effective AED Program is in place.

3. Definitions

Automated External Defibrillator (AED)- A small, portable, electronic medical device with a computer that will automatically analyze the heart rhythm. If the AED detects a life threatening abnormal rhythm, the AED will provide voice prompts and a visual message for the responder. The AED instructs the responder to move away from the victim and to push the shock button to deliver a life-saving shock. Or with fully automated AED's the AED will call to clear the victim and automatically deliver a shock.

Volunteer Responder- A volunteer responder is trained in CPR and the use of an AED and has received certification with a nationally recognized training institution. In the event a volunteer responder is not available to assist with an emergency, California law permits any individual acting in good faith and not for compensation to render emergency care or treatment by the use of an AED. In coordination with the
California state law Costa Mesa American Little League is expected to have volunteers or employees trained to use the AED.

Cardiopulmonary Resuscitation (CPR) - External chest compressions applied to a victim of Sudden Cardiac Arrest.

Emergency Medical Services (EMS)- Professional responders who are licensed and provide varying levels of service to a community to provide pre-hospital, immediate care for victims of sudden illness or injury and transport to a healthcare facility.

Risk-The chance of injury or illness as determined by the presence of hazards and/or the probability of an adverse event occurring.

Sudden Cardiac Arrest (SCA)- Sudden Cardiac Arrest is an electrical problem whereby the heart function ceases abruptly and without warning. The heart no longer pumps blood throughout the body and death occurs. While there are many causes for SCA the most usual cause is an arrhythmia known as ventricular tachycardia (VT) or ventricular fibrillation (VF) or both.

Heart Attack- A Heart Attack occurs when the heart muscle is deprived of adequate blood flow usually due to one or more vessels of the heart being blocked. The heart muscle damage can often be reversed with rapid interventions.

4. The Concepts of an Early Defibrillation Program

Early defibrillation should be used as one intervention for the problem of sudden cardiac arrest. Early defibrillation will succeed only when implemented as part of the Chain of Survival (see figure 1). The links of the chain of survival include immediate recognition of cardiopulmonary arrest and activation of 911 by trained responders, early CPR, and rapid defibrillation, effective advanced life support and integrated post-cardiac arrest care. Establishment of early defibrillation within a strong chain of survival will support improved survival rates. En-Pro Management, Inc. provides the resources and educational programs that support the cardiac chain of survival.

Figure 1. Chain of Survival

5. The Response Team Goal

The goal of the response team is to increase the rate of survival of people who experience sudden cardiac arrest or other life threatening medical emergencies. Effective programs deliver a care to a victim within 3 to 5 minutes of collapse.

Roles and Responsibilities Choosing dedicated individuals in the company or organization is essential to ensure an effective program.

A. Corporate Program Administrator
It is the responsibility of the Corporate Administrator to:
1. Oversee the implementation of the program
2. Designate the AED Site Coordinator(s)
3. Communicate with key decision makers
4. Review the program annually to evaluate effectiveness
5. Accurately maintain and update the PlusTrac online tracking site

B. Medical Director
The Medical Director provides program oversight, offers leadership and medical expertise to ensure safe implementation and is responsible to:

1. Develop and approve AED program protocols
2. Review and approve training programs
3. Communicate with Corporate Program Administrator and local EMS
4. Review all incidents involving the use of an AED
5. Provide post-event debriefing and support
6. Assure overall program quality. The Medical Director will have the authority to suspend or terminate volunteer responder privileges based upon deficiencies in compliance with En-Pro protocols, policies and procedures, training, or inappropriate actions that are not consistent with program policies.

C. Site Coordinator
It is the responsibility of the Site Coordinator to:

1. Communicate with En-Pro Management, Inc. with respect to:
   i. Medical Director and medical oversight ii. Corporate Program Administration, management and EMS notification iii. Volunteer responders
   iv. Compliance with En-Pro Management Inc.'s policies and procedures
2. Maintain a current list of trained volunteer responders
3. Facilitate event review, data collection and quality initiatives
   i. Notify En-Pro of AED use within 24 hours of deployment
4. Adhere to the En-Pro guidelines for maintenance and upkeep involving the AED(s) they are responsible for
5. Accurately maintain and update their PlusTrac online tracking site

D. Volunteer Responders

Volunteer responders are responsible to:

1. Successfully complete all mandatory training and skills evaluation as detailed by the AHA and the Medical Director
2. Comply with the Emergency Response Guide and respond to emergencies as designated
    1. Maintain current certification and participate in re-certification

E. En-Pro Management

It is the responsibility of En-Pro to:

1. Provide medical direction and oversight by a local Medical Director and comply with the guidance set forth by the Medical Director
2. Identify and review local and state regulations
3. Notify the local EMS or regulatory agency of the location of AED's where applicable by law or regulation
4. Identify local EMS policy and procedures and communicate them to the Corporate Administrator
5. Share AED use data per local and state regulations
6. Notify the Site Coordinator and Corporate Administrator of upcoming consumable or volunteer responder expirations in a reasonable amount of time so that replacements and re-certifications may be obtained prior to expiration.
7. Provide an online tracking system, PlusTrac, with which Costa Mesa Little League can periodically submit maintenance verifications. En-Pro will offer reminder notifications in a reasonable amount of time so that checks can be submitted before reaching an out of compliance status.

6. The Response Equipment

A. Description

The AED and other emergency response equipment support the chain of survival in the event of a SCA. Each device should be maintained according to policy and following the manufacturer's guidelines. The AED shall be applied to:

1. Unresponsive victims
2. Victims at least 8 years of age or 55 pounds
3. If Pediatric electrode or keys are available these can be applied to victims less than 8 years of age and/or less than 55 pounds

B. Location

The AED's will be placed in the location recommended by En-Pro Management, Inc. and the Corporate Program Administrator. AED's are placed for the most efficient response time to ensure that the response time goal of the AED program is reached. The AED should be stored with the appropriate accessories.

C. Accessories

Some state laws require a second set of pads and batteries to be compliant with the Good Samaritan laws and some AED manufacture's require spare sets of equipment to meet program warranty requirements.

All accessory equipment must remain with the AED and include the following:

Item Description	Quantity
Electrode Pads	1 or more
AED battery	1 or more
Rescue Essentials	1 or more

All equipment and accessories must be inspected routinely for readiness of use and integrity of device.

7. AED Maintenance

See Appendix I for the Periodic Maintenance Checklist

A. Report of Damage

-Follow the PlusTrac guidelines for all scheduled AED maintenance checks. -Report immediately, any defects, missing, damaged or expired accessories to En-Pro.

B. Required Maintenance Schedule

The Site Coordinator is required to complete the periodic Maintenance Verification checklist on each AED to ensure the quality of the AED program monthly.

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8. The AED Response Plan Overview

See Appendix II for the Response Plan

A. Call 911

Notifying Emergency Medical Services is the first link in the chain of survival and is a very crucial step. Any employee who has identified an emergency situation should activate the company's internal response plan and notify 911. Information that needs to be provided to 911 may include:

1. The type of emergency
2. The location of the emergency
3. A brief description of the victim including approximate age, gender, status of victim and CPR

2. Special access instructions to the site of the emergency

B. Volunteers' Respond

Volunteer Responders will provide care based on:

1. Scene safety
2. Victims condition and initial assessment
3. The emergency response plan

4. En-Pro Management, Inc. protocols

C. Transfer of Care

Upon arrival of EMS, the volunteer responders will transfer care to EMS, the volunteer responders may assist with care, if requested by EMS. Volunteer Responders will provide the following information to EMS:

1. Victim's condition upon the arrival of responder
2. Time of incident
3. All care provided to the victim

D. Post Incident Procedures

The Volunteer Responders will follow these procedures after the incident:

1. Log in to PlusTrac Vita to notify En-Pro of the AED Use
2. Complete the Post Incident Report Form
3. Complete post incident equipment maintenance
4. Participate in critical incident debriefing session

Notifying En-Pro will activate the loaner system so that a loaner AED may be sent to the site. The site address will be verified so that En-Pro may send a loaner AED and return shipment label to the site via UPS. The Site Coordinator must return their AED back to En-Pro in the loaner box utilizing the label provided. En- Pro will retrieve the event data from the AED and submit the information to the overseeing physician for review. Site Coordinators may also retrieve their event data and email it to their En-Pro Account Manager. Data cards may also be submitted in lieu of AEDs for data retrieval.

E. Critical Incident Debriefing

A critical incident debriefing session will be held as soon as possible following an event. This will be done on an informal basis. The purpose of debriefing is to:

1. Determine the need for emotional support for the volunteer responders
2. Evaluate the effectiveness and quality of the Emergency Response Plan
3. Determine the need for additional training
4. Recommend corrective actions

No changes to the Emergency Response Plan will be made without conferring with the Corporate Program Administrator, and the expressed authorization from En-Pro Management, Inc. based on consultation with and approval by the Medical Director.

9. Protocol Authorization

The Medical Director in consultation with En-Pro and the Corporate Administrator will review and approve all Emergency Response procedures including AED protocol and any addendums or changes.

A. Protocol Approval

The procedures and protocols are developed with guidance from En-Pro Management, Inc. for the specific use by Costa Mesa Little League.

B. Protocol Review

An annual review will be conducted to ensure quality and consistency with the program. No changes to the Emergency Response Plan will be made without conferring with the Corporate Program Administrator and the expressed authorization from En-Pro Management, Inc. based on consultation with and approval by the Medical Director.

C. Operational Guidelines

The protocol detailed in the Emergency Response Plan is intended for the Volunteer Responders.

D. Tracking Procedures

PlusTrac is the program developed by En-Pro Management, Inc. and will be used to track training requirements and will notify the Site Coordinator of expired certifications.

E. Protocol Qualifications

The required qualifications of the Volunteer Responders are:

1. Successful completion of AHA and/or any nationally recognized and approved training program
2. The minimum training to be completed is CPR and AED 3. Volunteer Responders perform only to the level of training completed and indicated on the certification card.
4. The Site Coordinator must identify and accept the Volunteer Responder as part of the Emergency Response Team i. New employees or volunteers that are added to the Emergency Response Team will be added to PlusTrac
5. Current certification must be maintained

10. Emergency Response Protocol

A. Initial Assessment

The first Volunteer Responder conducts an initial assessment to determine the level of response required from the team and local EMS. The initial assessment includes, but is not limited to:

1. Determine scene safety for self and other responders 2. Assess the victim; determine if the victim is responsive or unresponsive
3. Consider universal precautions prior to patient contact

B. Call 911

The first Volunteer Responder should activate the company internal response plan. A second responder should be sent to call 911.

If alone and no other person responds, the first Volunteer Responder should not delay and call 911 immediately.

The following information is to be provided to 911:

1. Type of emergency
2. Exact location of emergency
3. Any special access instructions
4. Victim assessment, responsive/unresponsive, breathing/not breathing, if known

Note: 911 may be able to assist with directions for care.

C. Retrieve the AED

If available, a second person or another responder should be sent to get the AED immediately. If alone, call 911 from a portable phone if possible so you can retrieve the AED while you call 911. If you are alone and no portable phone is available, retrieve the AED immediately after calling 911.

D. Begin CPR

A Volunteer Responder will provide CPR as follows:

1. Begin chest compressions
   i. Place hands in the center of the chest and push hard and fast ii. Compression rate should be at least 100 per minute iii. Compression depth should be at least 2 inches iv. Complete chest recoil should be allowed after each compression
   v. Minimize interruptions in compressions
3. Check the airway
   i. Open the airway with a head tilt, chin lift ii. Look for chest to rise iii. Listen for air movement iv. Feel for air/chest movement
4. Give two (2) breaths at one (1) second each that make the chest rise
5. If an AED is available allow it to analyze the heart rhythm
6. If no AED is available continue with chest compressions
   i. Push hard and fast at a rate of 100 compressions/minute
   ii. 30 compressions then 2 breaths

iii. Allow for complete chest recoil after each push

6. Continue until an AED arrives or EMS takes over or the victim becomes responsive
7. For untrained responders compression only CPR (Hand's only CPR) may be provided until a trained rescuer arrives.
8. If multiple rescuers are available they should rotate the task of compressions every two minutes.

E. AED Arrives

It is extremely important that the AED be used immediately. As soon as the AED arrives:

1. Power on the AED
   i. Open the AED ii. Push the on/off button iii. Follow the voice prompts
2. Follow the pictures on the AED electrode pads for proper placement
3. Perform any special procedures as needed
   i. Wearing protective gloves, remove any medication patches on the surface of the chest and then wipe the chest ii. Using supplied prep razor, shave excessive chest hair iii. Do not place AED electrode pad directly over implanted devices, however, move the pads slightly if possible iv. Dry the chest if wet so the AED pads adhere properly

F. Allow the AED to Analyze

When the AED pads are in place the AED will automatically analyze the victim's heart rhythm.

1. If SHOCK ADVISED
   i. Clear the victim – do not touch the victim ii. Press the flashing button to deliver the shock when prompted iii. Resume CPR immediately after the shock, the AED will prompt to resume CPR iv.Begin with compressions, continue with 30 compressions and 2 breaths v. The AED will re-analyze in two (2) minutes, follow the voice prompts
2. If NO SHOCK ADVISED
   i. Resume CPR immediately ii. Continue with 30 compressions and 2 breaths until the victim moves or breathes normally, or until EMS arrives iii. The AED will re-analyze in 2 minutes iv. Follow the voice prompts

G. AED Application Guidelines

Once the AED electrode pads are applied, do not remove them. Do not power off the AED. The AED will continue to monitor the patient's heart rhythm.

H. Patient Monitoring

If the victim becomes unresponsive again after regaining consciousness following a shock, the AED will

i. Reanalyze at the two minute cycle ii. May advise another shock

iii. Require the rescuer to press the shock button if an additional shock is needed

iv. Follow the voice prompts of the AED v. Resume CPR

I. Transfer of Care to EMS

Upon arrival of EMS, transfer patient care to the EMS team. Provide as much information as possible to EMS as requested.

J. Post Incident Report

Log in to PlusTrac within 24 hours of the event to notify En-Pro of the AED use.

11. Confidentiality

The Post Incident Report is part of the patient care record and is confidential information. This report is not to be copied or altered. Compliance with HIPAA is mandatory. Volunteer responders must refrain from any discussion with others about any aspects of the emergency, including outcome. A critical incident debriefing session will be held with the Volunteer Responders involved with the care of the patient. This is the only time that confidential information is allowed to be shared with the Medical Director and the AED Site Coordinator. This debriefing will be held via phone conference with the En-Pro Management Inc. Customer Support Manager.

12. Post Event Support and Data Retrieval

En-Pro Management Inc. will begin the post event services at no additional charge.

A. Data Retrieval

Notifying En-Pro of your AED use will activate the loaner system so that a loaner AED may be sent to the site. The site address will be verified so that En-Pro may send a loaner AED and return shipment label to the site via UPS. The Site Coordinator must return their AED to En-Pro in the loaner box utilizing the label provided. En-Pro will retrieve the event data from the AED and submit it to the overseeing physician for review and filing according to local requirements. Site Coordinators may also retrieve their event data and email it to their En-Pro

Account Manager. Data cards may also be submitted in lieu of AEDs for data retrieval.

B. AED Return to Service
Until the loaner device is received by the site inspect the AED for any damage and/or missing parts, wipe off with an approved cleaning solution, replace all supplies used during the event such as batteries and electrode pads. (If required by the manufacturer. Many batteries do not need to be replaced after every use. All pads must be replaced even if they were not applied to the victim. Once a package containing the pads has been opened pads can dry out so the entire package must be disposed of and new pads placed with the AED.)

13. Report Misuse or Defects
Any defects in the AED operation or deviation from the protocols established herein are to be reported to the Corporate Program Administrator and to En-Pro Management, Inc. Tampering with medical equipment, including the AED, will not be tolerated. Any suspected tampering and/or misuse must be reported immediately so the AED can be inspected for proper operation.

APPENDIX I – Periodic Maintenance Checklist (vita.plustrac.com Login Instructions)
En-Pro recommends that your AED Inspection be conducted and a record of this inspection be recorded into the database at vita.plustrac.com. You will enter a record of inspection for each device for which you are the AED Site Coordinator.

To check your device:

1. Go to the location in your facility where the device is located. Verify that the AED still indicates a "ready status." Refer to the manufacturer's guidelines for further information on verifying "ready status." 2. Check the expiration date on the electrode pads and the batteries. Note: The AED's self-diagnostic may detect the expiration status of your AED battery.

To enter the record of your inspection:

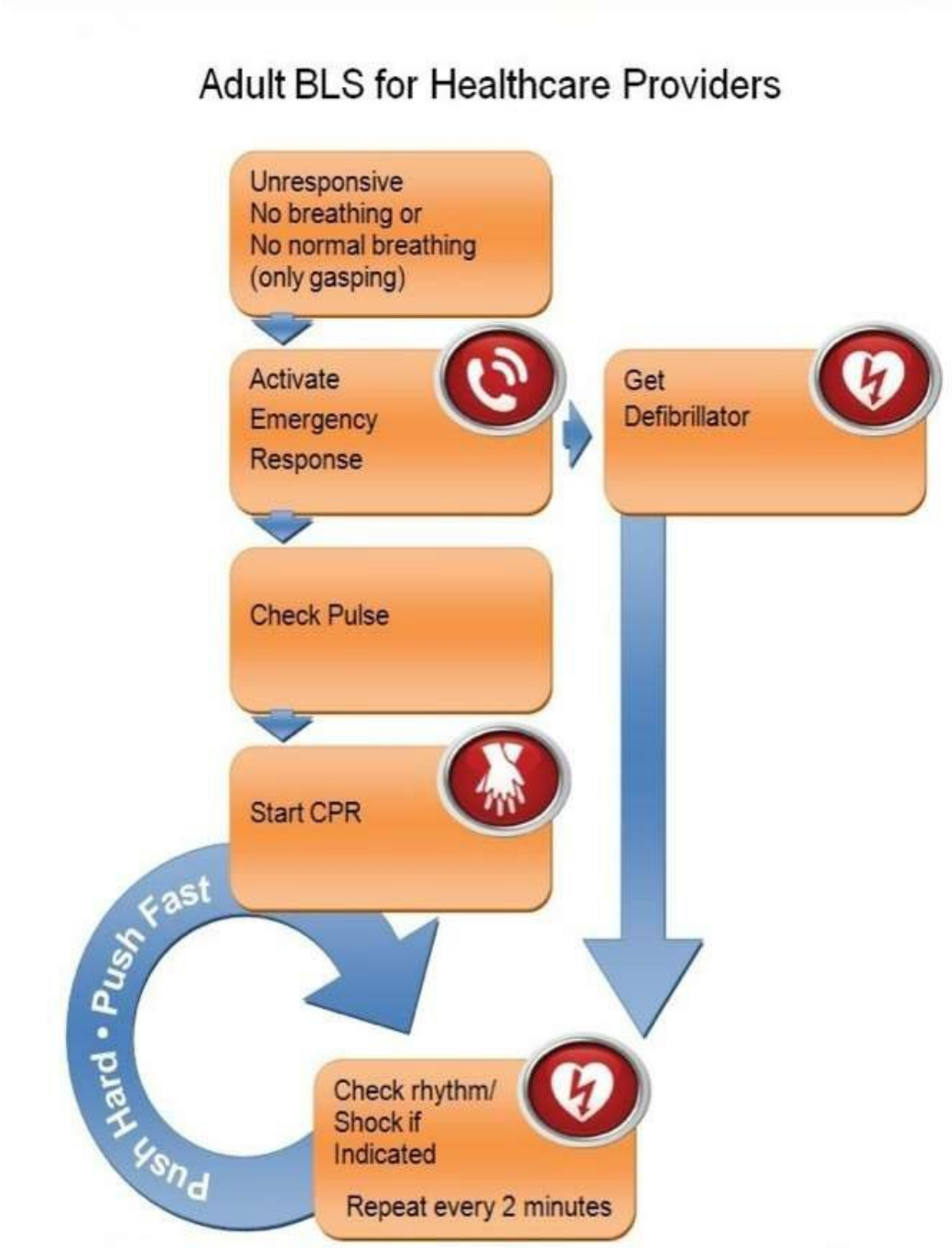
1. Go to vita.plustrac.com and log-in using your email address and Password.
2. Click on the "Check AEDs" button
3. Click on the green check if your AED is in ready status and ready to be deployed in an emergency. Click on the red X if something is wrong with your AED and it needs to be taken out of service.
4. A comment box will appear for you to log more information about the check if necessary.
5. Click 'OK' to submit your maintenance check.

What if something is wrong with my device?
If your device is not in ready status log your maintenance check using the red X option. Ensure that pads and batteries are still installed in your AED. Try powering the AED on then off. If you still experience difficulties, please contact En-Pro at 866-352-5433. We can put you in touch with the manufacturer or your sales rep for additional troubleshooting.

APPENDIX II – Response Plan
The following AED protocol is for use by the Volunteer Responders of Costa Mesa American Little League. The En-Pro Medical Director/Local Medical Director approves it for use by approved members only. The protocol will be reviewed on an annual basis and replaced by a revised protocol as necessary.
See the following AED Protocol Flow Chart.

1. Conduct an initial assessment:
    1. Assess for scene safety; use universal precautions.
    2. Assess patient for unresponsiveness and normal breathing patterns.
    3. Activate the company internal emergency response plan and call 911.
2. Ensure that 911 has been notified and that the local EMS response agency is enroute. When an emergency call is received, the following information must be obtained:
    1. Type of emergency
    2. Location of the emergency
    3. Breathing/Consciousness of patient and whether or not CPR is in progress
    4. Any special access instructions
3. Begin immediate chest compressions.
4. As soon as the AED is available, power on the AED and follow the prompts. Make sure that the AED pads are placed in their proper location and that they are making effective contact with the patient's chest. Do not place the AED pads over the nipple, medication patches, or implantable devices. It is vital that the electrode pads are placed on patient as soon as possible.
5. Deliver a shock to the patient when advised by the AED after first clearing the patient area. Call out CLEAR, VISUALIZE the area and then press the shock button. Continue with CPR beginning with chest compressions for two minutes until the AED re-analyzes the victim.
6. If no shock is advised, begin chest compressions immediately. After 30 compressions and if trained responders are available airway management and breathing can be included in the rescue event. 30 compressions to 2 breaths will be administered for two minutes until the AED re-analyzes or EMS arrives or the victim becomes responsive.
7. If the patient exhibits no pulse or respiration, continue to perform CPR until otherwise prompted by the AED, EMS medics, and/or the Medical Director.
8. Transfer patient care to EMS. No more than 24 hours following the event, document the SCA event and complete the AED Incident Report (complete all fields). Provide all documentation to the AED Site Coordinator/Corporate Administrator within 24 hours of the occurrence of the event. Log in to PlusTrac to report the AED use.

APPENDIX III – Adult BLS Response Algorithm



Storage Sheds and Procedures

The following applies to all of the storage sheds used by Costa Mesa Little League and apply to anyone who has been issued a key to use those sheds.

- All individuals with keys to equipment sheds (i.e., Managers, Umpires, etc.) are aware of their responsibilities for the orderly and safe storage of rakes, shovels, bases, etc.

- Before you use any machinery located in the shed (i.e., lawn mowers, weed whackers, lights, scoreboards, public address systems, etc.) please locate and read the written operating procedures for that equipment.

- All chemicals or organic materials stored shall be properly marked and labeled as to its contents.

- All chemicals or organic materials (i.e., lime, fertilizer, etc.) stored within these equipment sheds will be separated from the areas used to store machinery and gardening equipment (i.e., rakes, shovels, etc.) to minimize the risk of puncturing storage containers.

Any witnessed "loose" chemicals or organic materials within these sheds should be cleaned up and disposed of as soon possible to prevent accidental poisoning

MACHINERY
Tractors, mowers and any other heavy machinery will:

- Never be operated under the influence of alcohol or drugs (including medication) Not be operated by any person under the age of 16.
- Never be operated in a reckless or careless manner.
- Be stored appropriately when not in use with the brakes in the on position, the blades retracted, the ignition locked and the keys removed.
- Never be operated or ridden in a precarious or dangerous way (i.e. riding on the fenders of a tractor).
- Never left outside the tool sheds or appointed garages if not in use.

DISASTER PROCEDURES

In case of an unexpected disaster such as fire, earthquake, terrorist threat, etc, please stay calm and use the following procedures:

- All players should immediately go the Major Field and stay within the fenced field area.
- No child shall be permitted to leave unless they are released to their parents or guardian. o Do not let players go home with friends or others unless specifically approved by their parents.
- Manager, Coach or Volunteer should make every attempt to locate and contact player's guardian and not leave unattended.
- If unable to locate the player's guardian the volunteer must make every effort to get the player safely turned over to the proper authorities and or shelter in the area.

Mangers Safety Policy

As Managers in the Costa Mesa Little League, it is your responsibility to ensure the safety of your players at all times. The following is a list of safety related items. You must become familiar with this information prior to starting your practices.

1. Arrangements should be made in advance of all games and practices for emergency medical services. Determine the location of telephones nearest to the fields on which you play and practice. Have transportation available at all games and practices.

2. Safety Officers, Managers, Coaches and Umpires should have some training in First Aid. First Aid kits must be available at all games and practices. The Manager is responsible for the First Aid kit.

3. No games or practices can be held when weather conditions are not good, particularly when lighting is not adequate. The city of Costa Mesa has a Mudline (714) 754-5041 so that Managers can check field playability before using the field. Any problems with the field or facility that require assistance from a City Field Ambassador, please call (714) 925-7241.

4. Ball field area must be inspected before each game for holes, damage, stones, glass and other foreign objects. Practice fields must also be inspected. Do not commence a practice or game until the playing area is free of hazards.

5. Dugouts, bat racks and helmets should be placed behind the screens.

6. There is no on-deck circle. The only player handling a bat is the player who is up to bat. The on-deck player may not leave the dugout and approach the batter's box until the previous play is over and the umpire signals that play is ready to resume.

7. Only players, Managers, Coaches and Umpires are permitted on the playing field during games.

8. Responsibility for keeping bats and loose equipment off the field of play belongs to a regular player.

9. Inspect equipment helmets, chest protectors, throat protectors, shin guards, and bases often for unsafe conditions. Inspect bats for correct diameter, length, etc. Make sure that equipment fits players properly. Report all unsafe equipment to the Equipment Manager and cease using it immediately.

10. Batters must wear approved protective helmets during batting practice and at games.

11. All male catchers must wear athletic supporters with metallic, fiber or plastic cups during games and practices. All male players should wear supporters and cups.

12. Except when a runner is returning to a base, headfirst slides are automatic outs.

13. At no time should "horse play" be permitted on the field or in the dugout. Players should be seated in the dugout and should not be handling bats. Never allow players to throw bats or helmets.

14. Parents of players who wear glasses are encouraged to provide safety glasses with a retaining strap.

15. Players will not wear casts, watches, rings, pins, headgear or other metallic items.

16. Select those players whose lack of coordination might make them susceptible to injury and give them extra attention and training. Play these players at positions that minimize their risk of injury.

17. Catchers must wear facemask and protective cup while warming up pitchers during practice, games, in the bullpen and in between innings. During practices and games, catchers must also wear the chest protector while a hitter is in the batter's box.

18. No playing equipment is allowed lying around on the playing field.

19. Do not forget that safety also relates to the spectators, especially small children. Make sure that spectators are seated well behind the base lines.

20. No metal cleats are permitted. No metal pitching toe may be worn. Baseball shoes with rubber cleats molded to the sole or tennis or gym shoes are allowed.

21. Follow up on all accidents in order to discover the cause and to take corrective action, if possible. Report all injuries to the Safety Officer or the President.

22. Promptly complete the Accident Investigation Form. Be sure all questions are answered before signing claim and emailing it to the Safety Officer.

23. Inspect all players for proper uniform: cap, shirt (tucked in), pants, belt, socks, proper shoes, etc.

24. It is recommended that by the first practice or team meeting all players pass an annual physical exam.

25. The Manager must have the players registration forms with him at all times.

26. Do not jeopardize the health of the player by having them play when they are injured or ill.

27. Home plate umpires must wear chest protector and face mask.

28. If you have any questions regarding the severity of an injury, err on the side of caution and seek medical attention. Injuries that do not require emergency medical treatment must be brought to the attention of the player's parent/guardian as soon as possible.

29. During practice and games, while your team is at bat, keep all players in the dugout.

30. Report to the Safety Officer all conduct that you feel poses a potential threat to the safety of others.

31. Do not dispense any medication (including aspirin type products) without written parent permission.

32. Do not leave unaccompanied players alone on the field following a game or practice unless you have first received written parent permission. At the first practice or team meeting, advise parents regarding the procedure that you will follow in the event that players are not picked up immediately after practice and/or games. Stress to the parents the importance of picking up their children on time.

33. Obtain a written doctor's release before allowing a player to resume playing following a Little League related accident that required medical attention.

34. Properly warm up players before all games and practices to reduce the risk of injury.

35. No Manager or coach should be allowed to transport or be with a player alone, make sure there is always another coach, volunteer or parent present.

Insurance

WARNING: Protective equipment cannot prevent all injuries a player may receive while participating in baseball.

The Little League Insurance Program is designed to afford protection to all participants at the most economical cost to the local league. It is used to supplement insurance carried by the player's family, whether privately or by the parent's employer. If there is no other coverage, Little League insurance – which is purchased by the local league, not the parent – takes over and provides benefits for all covered injury treatment costs up to the maximum stated benefits. This plan makes it possible for Little League to offer unmatched, low cost protection with assurance to parents that adequate coverage is in force at all times during the season.

If one of your players sustains a covered injury while taking part in Little League Baseball or Softball, here is how the insurance works:

- First file a claim under the insurance covering the family.
- If the family's insurance plan does not fully cover the injury treatment, the Little League Insurance Policy will help pay the differences up to the maximum stated benefits. This includes any deductibles or exclusions in the insurance coverage.
- If the player is not covered by any insurance, the Little League Insurance Policy becomes the primary coverage and will provide benefits for all covered injury treatment costs up to the maximum benefits of the policy.
- 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 time treatment is given, even though it may be some years later. Maximum dollar benefit is $500 for eligible deferred dental treatment after the normal 52-week period. This is a brief summary of the Little League Insurance Program to give you some understanding of the program. In case of an accident, it is imperative that a "Notice of Accident" report be completed within 24 hours. A delay in accident reporting could jeopardize the player's coverage. Deliver the completed form to the President or Vice President as soon as possible.

Back Ground Checks & Volunteer Information

Costa Mesa Little League is required to obtain criminal background checks for all volunteer managers, coaches, board members, assistant coaches, umpires and any other persons, volunteers and/or hired workers who provide regular services to or who have repetitive access to, or contact with, players or teams.

These background checks are done through JDP and the results include state and federal criminal arrest records, and registered sex offender information. JDP does not provide notification of subsequent arrest after the background check is completed; therefore, background checks are completed annually. For additional information about Costa Mesa Little League's background check policy, please contact Costa Mesa Little League or JDP at www.jdp.com. Additional information on Little League Background checks can also be found at www.littleleague.org.

Pursuant to California State Law, Article 3 (commencing with Section 11100) of Chapter 1 of Title 1 of Part 4 of the Penal Code, criminal history information is used internally. Confidential criminal history information is not disclosed to the public.

Abuse Awareness Protocol

In 2018, the "Protecting Young Victims from Sexual Abuse and SafeSport Authorization Act of 2017" became Federal law. The mission of the U.S. Center for SafeSport is to make the athlete well-being the centerpiece of our nation's sports culture. All athletes deserve to participate in sports free from bullying, hazing, sexual misconduct, or any form of emotional or physical abuse. Education and awareness are the most critical components to creating safe and respectful sporting environments, free of abuse and harassment.
Little League Baseball and Softball have always strived to create a safe and healthy environment for all Little Leaguers and their families. There are certain requirements from the SafeSport Act that Little League International and all local little league programs must adhere to.

- Reporting of Sexual Abuse involving a minor to the proper authorities
  - All volunteers of a local league are now mandated reporters and could face criminal charges if the league chooses to ignore, or not report to the proper authorities, any witnessed act of child abuse, including sexual abuse, within 24 hours.
  - Local leagues must be aware of the proper procedures to report sexual abuse in their state. Please reference LittleLeague.org/ChildAbuse

- Leagues must adopt a policy that prohibits retaliation on "good faith" reports of child abuse
- Leagues must adopt a policy that limits one-one-one contact with minors
- Leagues are highly encouraged to complete the below Abuse Awareness training provided by USA Baseball and SafeSport

TO LEARN MORE GO TO >> https://usabdevelops.com/memberships/131/login

Abuse Awareness Protocol/ Live Scan Requirements

THE FOLLOWING IS A MESSAGE FROM LITTLE LEAGUE INTERNATIONAL THAT WAS SENT TO ALL LITTLE LEAGUES IN CALIFORNIA.

Dear California District and League Officers,
As a Little League® volunteer in California, we want to share an important update regarding a new state law to protect children from sexual abuse in youth organizations, including Little League. California passed a new legislative bill, Assembly Bill No.506, that requires a fingerprint-based background check and child abuse and neglect reporting training for individuals who volunteer more than 16 hours a month or 32 hours a year; which, for Little League, includes coaches, managers, board members, umpires, etc.
The bill requires organizations to have policies to ensure that regular volunteers are reporting suspected incidents of child abuse. It also requires the presence of at least two mandated reporters when interacting with children. This law will go into effect statewide on January 1, 2022. Fortunately, Little League International has the Child Protection Program that must be followed by all Little League programs and volunteers are already considered mandated reporters due to the SafeSport law enacted in 2018 .

What Leagues Need to Know:

The new background check requirement by the state is pursuant to Section 1105.3, which is a California Department of Justice State fingerprint check through Live Scan locations. This background check does not replace the required Little League background check , which is a search of the National Criminal database, National Sex Offender Registry, U.S. Center for SafeSport Centralized Disciplinary Database, and the Little League International Ineligible List. Local Little League volunteers must conduct training for child abuse and neglect reporting training. Leagues can utilize the USA Baseball training, which is free to all volunteers: Abuse Awareness for Adults.