

WFTDA

Risk Management Guidelines

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WFTDA Risk Management Guidelines

1. Purpose	1
2. Spectators and seating	1
2.1. Spectators and seating	1
2.2. Barriers	1
2.3. Infield, Skating and Competition Surfaces	2
2.4. Medical Staff Seating	2
2.5. Skating Surface	6
2.6. Security	6
3. Protective Gear	6
3.1. Required Gear	6
3.2. Optional Gear	7
3.3. Functionality, Safety, Gameplay	7
4. Safety Personnel and Staffing Levels	7
4.1. Safety Personnel	7
4.2. Staffing Levels	8
5. Concussion, Injury and Impairment	9
5.1. Definition of a Concussion and its Risks	9
5.2. Reference on Concussions in Sports	9
5.3. Legal Consideration	9
5.4. Potential Concussion Assessment	9
5.5. Participants Deemed to Have Potentially Incurred a Concussion	10
5.6. Return to Play Following a Potential Concussion	11
5.7. Injured/Ill Athletes Returning to Play	12
5.8. Substances and Impairment	12
6. Blood-Borne Pathogens (BBP)	12
6.1. Biohazard Clean-up Kit	13
6.2. Procedure to Clean Biological Hazards	13
6.3. Hard-Surface Disinfectant Spray	14
7. Emergency Action Plan (EAP)	15
8. WFTDA Insurance Documentation	15
Appendix A: Risk Coordinator Job Description	17
Appendix B: SCAT5; Concussion Resources	19
5th International Consensus Statement on Sports Concussion (AKA SCAT5)	19

Appendix C: Examples of Return to Play	21
Example of a Medical Clearance Form	22
Example of a Medical History Form	22
Appendix D: Emergency Action Plan (EAP) Template	23
Appendix E: Recommended Medical Supplies	26
Appendix F: Useful Links	27

1. Purpose

The *WFTDA Risk Management Guidelines* have been developed in order to increase awareness and help members reduce the risks to individuals and organizations from damages and unexpected injuries in the sport of roller derby. These guidelines include minimum standards and recommendations for WFTDA members and may be considered best practices for all roller derby organizations.

The following guidelines apply to all games, practices, and other activities when WFTDA insurance is in effect, and also to all WFTDA-sanctioned games, regardless of insurance coverage.

Compliance with these guidelines is a condition of coverage of the WFTDA Insurance General Liability and Accident Medical policies. The WFTDA Insurance Administrator must specifically approve in writing any deviations from these guidelines. Noncompliance with the *WFTDA Risk Management Guidelines* is grounds for denial of insurance coverage.

Information about injury prevention and risk management evolves on a constant basis. As a result, the *WFTDA Risk Management Guidelines* are modified and updated regularly. If you have questions, comments or suggestions, please email riskmanagement@wftda.com. Emails are seen by the Risk Management Committee Chair and may be shared with the Risk Management Committee.

Questions and comments regarding Section 2 and 8 of these guidelines may be directed to insurance@wftda.com.

2. Spectators and seating

2.1. Spectators and seating

- MINORS: Spectators under 18 years of age may only be present in areas designated Zone F. When no barrier is present they must not sit within 15 feet (4.6 meters) of the OUTER TRACK LINE.
- Spectator seating such as chairs, bleachers, benches and floor chairs with rigid supports, must be located in Zone F.
- TRACKSIDE floor seating (Zone E) will not encroach within 10 feet (3.0 meters) of participant access between team benches, penalty box and the track.
- All SPECTATORS and PARTICIPANTS in TRACKSIDE SEATING (Zone E) must be seated, with their limbs and possessions completely behind the OUTER OFFICIATING LANE boundary line.
- The arrangement of seating (trackside or general) shall provide ready egress by aisle paths. These shall not be obstructed.

2.2. Barriers

The purpose of a BARRIER is to prevent participant contact with spectators, objects, structures, and other hazards.

Only BARRIERS that meet the criteria in this Guideline are permitted on the SKATING SURFACE.

- BARRIERS must be fixed to the floor and a minimum of 36 inches (91 cm) high.
- A BARRIER may be present in Zone D if it approaches no closer than 5 feet (1.52 meters) to the OUTER TRACK LINE.
- Smooth, continuous BARRIERS do not need to be padded. All rough surfaces, protrusions, or sharp edges on a barrier within 15 feet (4.57 meters) of the OUTER TRACK LINE must be padded.



- All doors or openings present in a BARRIER that lies within 10 feet (3.05 meters) of the OUTER TRACK LINE must be closed or blocked off during active skating.
- The area to the outside of the BARRIER is considered UNRESTRICTED (Zone F).
- Bumper pads are not considered a BARRIER, and may be used at the 10 feet (3.05 meters) line, where trackside, floor seating begins. TRACKSIDE SEATING (Zone E) seating restrictions remain in place.

2.3. Infield, Skating and Competition Surfaces

- No structures, speakers, lights or other objects shall protrude overhead above the INFIELD and SKATING SURFACE (Zones A, B, C, D and E) within 10 feet (3.05 meters) of the floor.
- No structures speakers, lights, chairs, bleachers or other objects shall be present on the SKATING SURFACE (Zones B, C, D and E).
- Posts may be present in the INFIELD (Zone A) if padded. Padding should be dense foam and a minimum of 3 inches (7.62 centimeters) thick. Posts may not be present in zones B, and C. Posts may be present in zone D only IF there is a barrier > 5 feet (1.524m) from the OUTER TRACK LINE of zone C, and the post is located outside the barrier. Posts may be integrated into the barrier if they do not present additional risk to participants.
- No discontinuities or abrupt changes in the floor may be present on the INFIELD and COMPETITION SURFACE (Zones A, B, C, D).
- Team benches and photographers box may be located in the INFIELD (Zone A) in an area that is clearly demarcated.
- The Penalty Box and team benches (if team benches are not in the INFIELD) , must be located to the outside of the COMPETITION SURFACE (Zones B, C and D) in Zone E, but must be placed at least 2 feet (.61 meters) away from the OUTER OFFICIATING LANE (or 12 feet/3.66 meters from the OUTER TRACK LINE).
- During a jam, only Skaters in the jam and Officials may be on the COMPETITION SURFACE (Zones B, C, And D).
- PARTICIPANTS located in the INFIELD (Zone A) may return to their designated area if they can exit safely without interfering with gameplay.

2.4. Medical Staff Seating

- Emergency medical personnel will be provided seating that offers an unimpeded view and clear access of the entire track.
- Additional unassigned seating should be provided in their demarcated area to allow seating options for treatment and observation.



TABLE 1: FACILITIES SECTION GLOSSARY

Term	Definition
Participants	Skaters, Officials, production staff (All participants are required to sign the WFTDA liability waiver prior to participation.)
Spectators	Non-participants, general public
Minors	Under 18 years of age (or age of legal adulthood, at location of participation)
Skaters	Skaters and Skating Officials
Officials	Skating Officials, Non-Skating Officials
Infield	Zone A. 5 feet (1.52 meters) from inside of ITL.
Inner Officiating Lane	Zone B. Begins at the ITL and extends inward 5 feet (1.52 meters).
Inner Track Line (ITL)	Inside boundary of the Track, dividing Zone B and C
Track	Zone C.
Outer Track Line (OTL)	Outside boundary of the Track, dividing Zone C and D
Outer Officiating Lane	Zone D. Starts at OTL, extending ≥ 5 feet (1.52 meters) to a barrier, or 10 feet (3.05 meters) if no barrier.
Bench, Box Ingress/Egress	Classed as Zone D although 12 feet (3.66 meters) from OTL. No Spectator Trackside Seating permitted within 10 feet (3.05 meters) of skaters' ingress and egress between track and box or bench.
Barrier	Meets all of the requirements of the Barriers section of these Guidelines
Trackside Seating	Zone E. Between 10 feet (3.05 meters) and 15 feet (4.57 meters) from the OTL. Not in front of team benches, penalty boxes or medical staff area.
Skating Surface	Zones B-E
Competition Surface	Zones B-D



TABLE 2: SAFETY REQUIREMENTS BY ZONE FOR SELECT EXAMPLES

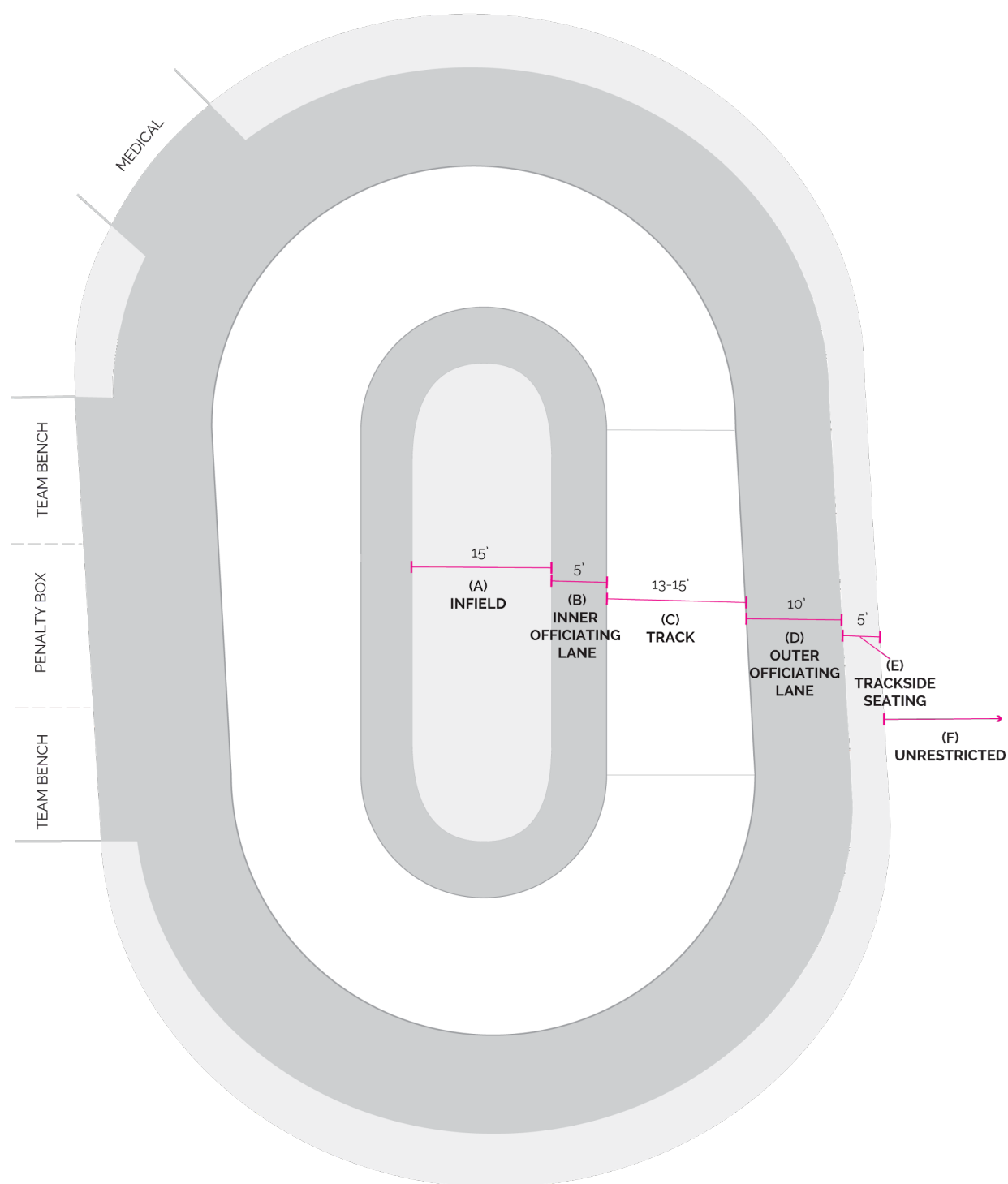
<i>Facilities Zone</i>	<i>INFIELD*</i>	<i>INNER OFFICIATING LANE</i>	<i>TRACK</i>	<i>OUTER OFFICIATING LANE</i>	<i>TRACK SIDE SEATING</i>	<i>UNRESTRICTED</i>
Safety Requirements	A	B	C	D	E	F
Minors <18 years						OK
≥18 years Spectators (non-Participants)					OK	OK
Bleachers, spectator seating						OK
Wheelchairs (public seating), chairs with exposed rigid supports						OK
Penalty Box					≥12 feet (3.66 m) to OTL	OK
Team Benches (including participants using wheelchairs, knee scooters, etc.)**	OK				≥12 feet (3.66 m) to OTL	OK
Structural posts, if padded	OK					OK
Overhead objects or features <10 feet (3.05 meters) above floor						OK
Barrier or Wall				≥5 feet (1.52 m) to OTL	OK	OK
Photographers Box (demarcated, no chairs)	OK				OK	OK
Medical responders designated area						OK

*Non-skating officials using medical apparatus may be located in the Infield (Zone A) in an area that is clearly demarcated. (As per 2.3.)

**Bench staff using medical apparatus may travel in and out of other zones as applicable when active game play has stopped.



FIGURE 1: TRACK LAYOUT WITH ZONES (Original Track Design © 2002 Electra Blu/Amy Sherman, Texas Rollergirls, used here with permission.)



2.5. Skating Surface

- The skating surface must conform with *The Rules of Flat Track Roller Derby*, and be flat, clean, and clear of cracks and debris. The WFTDA recommends smooth concrete or sport court.
- If using sport court, it must be well maintained, free of breakage, and must provide full coverage in Zones A, B, C and D.
- Any raised boundary must be no more than 0.5 inch (1.27 centimeters) in height and must be marked in such a way that is highly visible to Skaters and Officials and does not present a safety hazard. Small indentations may be taped over to ensure a smooth skating surface.
- Rubber-coated or other soft-surface flooring is NOT recommended.

2.6. Security

The host league will be responsible for staffing a sufficient number of security staff to:

- Meet the requirements for safety and security as required by the venue.
- Keep spectators and unauthorized persons off of the COMPETITION SURFACE.
- Monitor the facility or venue doors, ensuring that everyone who enters the facility or venue is authorized to enter.
- Ensure that spectators and unauthorized persons are not in restricted areas, such as staff areas, staging areas, or locker rooms.
- Address security and safety situations following your league's emergency action plan and any venue guidelines.
- In case of injury, assisting to keep a path clear for entry and exit of Emergency Personnel.
- In case of emergency, assisting event Risk Coordinator and/or Facility staff in evacuation of the facility detailed in the site or venue Emergency Action Plan (EAP).

3. Protective Gear

3.1. Required Gear

Skaters (including Skating Officials), when on skates must wear all protective gear that includes at a minimum:

- Wrist guards, elbow pads, knee pads, mouth guards, and helmet.
- Wrist guards, elbow pads, knee pads, and helmets must have a hard-protective shell or inserts.
- Skating Officials may forgo the use of mouth guards
- Skaters not actively competing or engaging in contact drills may forego the use of mouth guards.

Gear must be designed for skating, well-fitting, worn correctly, and in good condition. Proper fit and maintenance of gear is the responsibility of the Skater. Skaters are strongly encouraged to repair or replace pads that have ineffective Velcro.

Coaches, bench staff and off-skates volunteers and officials working in zones A, B, C, D and/or E must wear closed-toe shoes.

3.2. Optional Gear

- Optional protective gear including padded shorts, chin guards, knee or ankle support, shin guards, turtle-shell bras, protective cups, tailbone protectors and form-fitting nose guards may be worn at the Skaters' discretion as long as they do not impair or interfere with the safety or play of other Skaters, support staff, or Officials.
- Full-face shields and half-face shields are permitted as long as they are transparent, meaning the wearer can be distinctly seen.
 - Mirrored and iridium visors are not permitted because they are not transparent on both sides.
 - Visors must be fixed in place during game play (not raised).
- Chin guards, turtle shell bras, cups, tailbone protectors, shin guards, non-form-fitting clear full-face shields, non-form-fitting clear half-face shields, and form-fitting face shields such as nose guards may have a hard-protective shell. No other optional protective gear may have hard protective shells.
- Non-form-fitting full- and half-face shields must be designed for use on the brand and type of helmet with which they are paired.
- Cage-style face shields are not permitted
- Casts are permitted if they do not present a hazard to other Skaters. They do not require padding. A wrist guard is not required over a cast that extends to the wrist.

3.3. Functionality, Safety, Gameplay

- Skaters are responsible for the condition of their required and optional gear. Leagues may assign someone to check their teams' gear prior to commencement of competition.
- Safety gear, uniforms, and optional features worn by a participant must not pose safety risks to other participants (e.g., safety gear, adornments with sharp edges, etc.). The Head Referee has the authority to require a participant to replace or mitigate potential safety hazards or remove the participant from gameplay when no reasonable alternatives are available. Officials and the game or host league Risk Coordinator are able to notify a Skater before and during gameplay if their protective gear is noncompliant. The Skater then must resolve the issue before returning to gameplay.
- Jewelry may be worn during gameplay unless deemed a safety hazard by the Head Referee. It is recommended that jewelry be taped or removed. Jewelry must not interfere with gameplay or cause danger to other Skaters. Jewelry is worn at the risk of the wearer.
- Nails should be trimmed to no longer than ¼ inch (0.64 centimeter), as measured from the fingertip. If nails are longer than ¼ inch (0.64 centimeter), each finger must be taped.

4. Safety Personnel and Staffing Levels

It is the responsibility of each league to be aware of any applicable civic ordinances, regulations and/or laws of their local area pertaining to requirements for medical personnel for crowd support during events as these requirements may be more stringent than the WFTDA requirements outlined here.

4.1. Safety Personnel

The following are definitions and responsibilities for key Safety Personnel (also referred to as "Medical Staff" and "Safety Staff").

Risk Coordinator: Leagues are required to staff a Risk Coordinator whose role includes ensuring league activities meet these Guidelines as well as being the primary liaison to the WFTDA Risk Management Committee. For competitions, the host-league or tournament designated Risk

Coordinator (may be a different person than league Risk Coordinator) ensures the requirements in these Guidelines are met for the event. They are the primary contact between the leagues, the Venue management, medical staff and the Officials in regards to safety questions or issues that arise during the event. They review the Emergency Action Plan for the venue prior to the event and review safety and evacuation guidelines with the volunteers and/or facility people staffing Security (per section 2.6). Additional responsibilities for league and event Risk Coordinators are included in [Appendix A](#).

Professional Medical Staff: Volunteer or hired professional Medical Personnel. Medical licensure and certification might include:

- Certified First Responders (CFRs), Emergency Medical Technicians (EMTs), or Paramedics
- Physician with sports medicine, orthopedic, and/or emergency medical experience
- Athletic trainer with CPR training
- Licensed Practical or Registered Nurse with current CPR training and sports medicine, orthopedic, and/or emergency experience
- Nurse Practitioner or Physician's Assistant with current CPR and sports medicine, orthopedic, and/or emergency experience

Volunteer Safety Staff: League members or volunteers who attend to medical situations within their level of training. Volunteer Safety Staff should be trained at least to the minimum Basic or Emergency First Aid training as recognized in their locale and supply an in-date certificate if requested. The first aid training should be a recognized standard of practice for the country of origin and should provide certification of training for recognition of life-threatening emergencies and the ability to provide basic lifesaving techniques.

Examples of qualifying training include but are not limited to American Heart Association or American Red Cross First Aid with CPR in the US, Level A Emergency First Aid through the British Red Cross, or St. John Ambulance in the UK.

League Physician: It is recommended that each league have an ongoing Medical Staff, including a licensed physician, working with and backing up the Emergency Medical Staff in person and/or by phone. A physician would help coordinate with a Skater's personal doctor to expand the care and follow up rendered. A continuing medical presence would also provide an opportunity for the development of safety data and procedures to prevent injuries. Retired physicians, sports medicine or orthopedic training programs, or a medical group that has treated Skaters from the league are all possible sources.

4.2. Staffing Levels

Leagues will ensure that Safety and/or Medical Personnel are present based on the following levels:

- **Internal league practices** (e.g., endurance skating, light contact drills, passive blocking, stopping, and general skating skills development)
 - **Minimum Standard:** One Volunteer Safety Staff. Resources for this level need not be dedicated and may include a Skater, coach, or Official who meets the Volunteer Staff criteria. It is also recommended that if Volunteer Safety Staff is on skates, an additional Volunteer Safety Staff be engaged.
- **Interleague/Intraleague practice and scrimmage** (competitive game situations e.g., practice with full contact drills, opposing teams, and scrimmages with timed jams and/or periods)
 - **Minimum Standard:** One Volunteer Safety Staff. Resources for this level need not be dedicated and may include a Skater, coach, or Official who meets the Volunteer Staff



- criteria. It is also recommended that if Volunteer Safety Staff is on skates, an additional Volunteer Safety Staff be engaged.
- **Recommended Level:** Two Professional Medical Staff with one available to treat patients at all times. It is understood and recognized that this recommendation may not be feasible for all leagues and situations.
- **Interleague/Intraleague games and Tournament play, including sanctioned and regulation games.**
 - **Minimum Standard:** Two Professional Medical Staff with one available to treat patients at all times. Resources for this level are to be dedicated to the event and should not have another role in the game, which may cause distraction from the expected duties. If at any time the Medical Staff become involved in the care and treatment of an athlete or spectator, play should stop until an equivalent replacement for the Medical Staff can resume game support or the patient is transferred to other equivalent Medical Staff. These resources should be quickly accessible from the track and have quick access to the track.

5. Concussion, Injury and Impairment

5.1. Definition of a Concussion and its Risks

A concussion is a type of traumatic brain injury caused by a bump, blow, or jolt to the head that can change the way the brain normally works. Concussions can also occur from a blow to the body that causes the head to move rapidly back and forth. Concussions should be suspected in the presence of any one or more of the following: symptoms (e.g., headache, nausea), physical signs (e.g., unsteadiness, loss of coordination), impaired brain function (e.g., confusion, aggression), or abnormal behavior.

Concussions are serious injuries and will occur in roller derby. The risk is extremely high for second-impact syndrome (SIS) if someone is re-injured before symptoms of an earlier concussion have subsided. SIS can be catastrophic and even fatal. The brain should be sufficiently rested and recovered before returning to play.

5.2. Reference on Concussions in Sports

The WFTDA Risk Management Guidelines and policies related to concussions have been developed in consideration of the Consensus Statement on Concussion in Sport, — the 5th international conference on concussion in sport held in Berlin, October 2016 published in: Br J Sports Med 2017;51:838-847, McCrory P, Meeuwisse W, Dvořák J, et al. The full text of this document is free and available at: <http://bjsm.bmj.com/content/51/11/838>.

5.3. Legal Consideration

Member leagues and roller derby organizations hosting events and activities (including practices and skills development activities as well as games and tournaments) must be familiar with local, state/province, and national laws related to concussions in youth sports when these activities involve youth participants and must comply with the provisions of these laws.

5.4. Potential Concussion Assessment

Member leagues and roller derby organizations hosting events and activities (including practices and skills development activities as well as games and tournaments) must identify the person(s) responsible for conducting potential concussion assessment of participants who have been



observed to experience conditions where a concussion may occur. These situations include receiving a significant blow to the head from contact with the floor or other participants, or other physical actions where significant force may have impacted the head (e.g., a violent shake). Participants who observe actions where a concussion may have occurred should discuss their observations with a Head Official or Volunteer Medical Staff.

The most qualified person(s) should be on hand for potential concussion assessment and must operate within their scope of practice and certification.

It is recommended that person(s) responsible for potential concussion assessment be formally trained in concussion management.

The minimum standard for public events and formal games is to engage a volunteer who is an athletic training or medical professional familiar with concussion symptoms and assessment. The volunteer must operate within their scope of practice and training.

The minimum standard for all roller derby activities is to engage a volunteer who is familiar with the Concussion Recognition Tool (see [Appendix B](#))
<http://bjism.bmj.com/content/bjsports/early/2017/04/26/bjsports-2017-097508CRT5.full.pdf>

It is recommended that leagues and roller derby organizations encourage volunteers who will administer potential concussion assessments to complete online training courses equivalent or superior to Centers for Disease Control (CDC) Heads Up Concussion Training (www.cdc.gov/concussion/Headsup/training/index.html).

It is recommended that leagues and roller derby organizations incorporate regular baseline concussion assessment testing and engage appropriately trained and certified staff to administer the baseline and on-site potential concussion assessment testing when possible. Examples of concussion management systems that may be used include SCAT5 (International), Multimodal (primarily Canada), ImPACT (US & Canada). It is important to continue to monitor concussion testing system quality and acceptance in the medical community as the knowledge base is continually changing.

5.5. Participants Deemed to Have Potentially Incurred a Concussion

When a participant (Skater, coach, or Official) shows any signs of a potential concussion or an action where it is reasonable to suspect a blow to the head and/or body has been observed, the participant must be assessed for potential concussion symptoms. The assessment should occur shortly after the incident, but the participant may request a short time to rest before being assessed.

If the participant is unconscious or unresponsive at any time following the acute injury, professional medical services must be engaged (e.g., 911 emergency call and transport to medical facilities for care and disposition). The participant may not return to play or other activities without medical clearance.

A volunteer trained in concussion recognition and management in sports may follow their scope of practice and guidelines in managing concussion assessments and monitoring participant activities including provisional continued participation. As concussion symptoms may take several hours to manifest, the concussion assessment volunteer may require the participant to return for continued assessment and observation. For example, a participant may be required to check in with volunteer responsible for concussion assessment before warming up for their next game in a multi-game event.

When the minimum standard for concussion assessment is employed (volunteer using the Concussion Recognition Tool), a single symptom is grounds for removing the participant from further activities.



Failure to comply with an assessment is grounds for removing the participant from further activities.

An Injury Report is required for WFTDA Insurance and may be required for other insurance providers. It is recommended that an injury report be completed for each incident a participant is assessed for a potential concussion regardless of the insurance coverage.

A participant who is assessed for a potential concussion should not be left alone and should be continually monitored for signs of a potential concussion for several hours (including overnight) regardless of the outcome of the assessment.

5.6. Return to Play Following a Potential Concussion

A participant who is determined to show signs of a concussion following assessment may not return to play on the day of the injury. A participant who is determined to show signs of a potential concussion following assessment may return to play under medical or athletic training supervision by a professional trained and certified in return to play following concussions. It is recommended that the participant follow the graduated return to play protocol identified in Table 1 of the Consensus Statement on Concussion in Sport (Section 5.2) A link directly to that table is here: <http://bjsm.bmj.com/content/51/11/838#T1>.

TABLE 3: GRADUATED RETURN TO PLAY PROTOCOL

If at any point symptoms return, drop back to previous (or earlier) step.

Rehabilitation Stage	Functional exercise at each stage of rehabilitation	Objective at each stage
1. No activity	Symptom-limited physical and cognitive rest	Recovery
2. Light aerobic exercise	Walking, swimming, or stationary cycling, keeping intensity <70% maximum permitted heart rate. No resistance training.	Increase heart rate
3. Sport-specific	Non-contact skating drills, endurance skating, speed skating	Add movement
4. Non-contact training drills	Progression to more complex training drills, still non-contact. May start progressive resistance training.	Exercise, coordination and cognitive load
5. Full-contact practice	Following medical clearance, participate in normal training activities.	Restore confidence and assess functional skills by coaching staff
6. Return to play	Normal gameplay	

"Once concussion-related symptoms have resolved, the athlete should continue to proceed to the next level if the athlete meets all the criteria (e.g., activity, heart rate, duration of exercise, etc.) without a recurrence of concussion-related symptoms. Generally, each step should take 24 hours, so that athletes would take a minimum of 1 week to proceed through the full rehabilitation protocol once they are asymptomatic at rest." (Consensus Statement on Concussion in Sport, --the 5th International Conference)



Note however that guidance varies, as the current UK NHS for concussion is to avoid sports or strenuous exercise for at least a week, and to avoid contact sports for at least three weeks.

5.7. Injured/Ill Athletes Returning to Play

In all cases, the health and well-being of the participants must take precedence, not the game situation or outcome.

Leagues are encouraged to develop and adopt their own Return to Play policies with clear and specific guidelines for what to do following a serious injury or contagious illness. These league-specific policies should include and be consistent with the standards of the *WFTDA Risk Management Guidelines*. It is incumbent upon league coaches, Captains, and Officials to communicate with each other in advance of any scrimmage or game to ensure all participants meet the league's defined criteria for Return to Play. Enforcement must occur at the league level. Please see [Appendix C: Examples of Return to Play Policies](#).

Ultimately, the participant is the decision maker on return to play following an injury—with the exception of concussions. It is their decision on whether or not to participate in the sport. (This is not the case in youth sports as there may be legal requirements for non-adult participants).

The participant should seek the best medical advice and counsel possible in returning to play following an injury. While pain is a good indicator for return to play, it is not always an indicator and some injuries may require a longer recovery and more active development to reduce the risk of re-injury. Failure to seek medical care and follow advice may affect insurance coverage for re-injury. Fit to play is a lower standard than fit to perform. Avoiding re-injury is an important consideration in determining fit to play.

Returning to play following an injury or other health-related issues must not increase the risk of injury or health of other participants. For example, appliances such as casts should not pose a risk to other participants. Participants with highly contagious conditions should not participate unless their condition has been determined safe for others by a medical professional.

5.8. Substances and Impairment

- Persons may not actively participate in any derby activity, on or off skates, while impaired. This includes being under the influence of any substance that affects or impairs that person's judgment, ability, and/or motor skills. Impaired persons put all participants at risk and are unacceptable.
- Persons using substances to treat acute or chronic medical conditions (therapeutic use) are not prohibited so long as:
 - they do not impair a person's judgment, ability, and/or motor skills beyond what is considered their normal state of health following treatment, and
 - the absence of the substance would result in serious impairment to the health of the person.
- Participants are still required to follow the laws of whatever jurisdiction, local, state, federal, or international, they are in while involved in derby activities. This provision does not grant permission to ignore the laws of any jurisdiction which makes a substance illegal to possess or use.

6. Blood-Borne Pathogens (BBP)

Occasionally blood and other bodily fluids end up on the track, gear and/or clothing. When approaching clean-up, minimize the risk of infection by approaching blood and bodily fluids (not



including sweat) as if they were infected with a blood borne pathogen such as HIV, Hepatitis B or Hepatitis C. Though not all blood and/or body fluids will contain communicable pathogens, standard precautions state we should treat all body fluids as if they have known pathogens.

Participants with active bleeding should be removed from the track and immediately taken to a designated area. Bleeding must be stopped and the open wound covered with a dressing sturdy enough to withstand the demands of play before the participant may continue to participate in practice or competition. Any participant (not just the injured) whose uniform is saturated with blood must change their uniform before continuing to participate. If blood is on the hard surface of a participant's gear, it should be cleaned with an approved broad-spectrum hard surface disinfectant. Fabric areas of gear should be securely covered with duct tape or removed at the discretion of Safety Staff.

The Risk Coordinator is responsible for designating a person to clean up blood and fluids on the track, and ensuring that person has access to the clean-up kit and knows how to use it properly. Track clean-up is the responsibility of the home league – medical staff may help but floor clean-up is not their job function.

6.1. Biohazard Clean-up Kit

A kit, bucket, box or bag containing the following items should be available for use at trackside. The kit contains the minimum set of items for safe containment and clean-up of blood splatters and other bio-spills, and to decontaminate exposed hard surfaces (e.g. floor).

The kit must consist of:

- Disposable gloves
- Paper towels
- Empty sealable bags (large enough to hold saturated clothing items)
- Black permanent marker
- Spray bottle with approved hard-surface disinfectant (see 6.3). Note 'replace by or expiration' date on bottle. Follow instructions on the label for required contact time.

6.2. Procedure to Clean Biological Hazards

1. Apply disposable gloves.
2. Spray surface with supplied hard surface cleaner. Wipe up contaminated area.
3. Place the waste in a sealable moisture-proof bag or container.
4. Re-clean the entire area until the entire blood spill is cleared (i.e., paper towels no longer have any red tint).
5. Place all contaminated waste in a sealable, moisture-proof bag or container that is marked "Bio hazardous." Dispose of the bag or container in a manner that will not lead to exposure of the contents and in accordance with local law.
6. Do not touch anything or anyone else until gloves are removed (e.g., use your feet to open a door).
7. Remove gloves. With both gloves on, remove one glove but do not touch anything but the glove and discard. To remove the other glove, take the index finger and place it inside the glove where no fluids have touched, and remove carefully. Do not touch the outside (contaminated) surface of the gloves with bare skin at any time.
8. Dispose of gloves.
9. Wash hands with soap and water for a full minute.



6.3. Hard-Surface Disinfectant Spray

Select a broad-spectrum disinfectant spray that the label notes is a tuberculocide, and/or it is effective against HIV and Hepatitis-B (HBV). If 1:10 household bleach solution is used, ensure that there is a process in place to keep it restocked every couple of weeks; as a months-old bottle of bleach water in the spill kit will not be effective. QUAT solutions are recommended for their efficacy and long-storage life. Brands and products available regionally may be found through local medical facility contacts and supply stores.

TABLE 4: COMPARISON OF RECOMMENDED HARD-SURFACE DISINFECTANT SPRAYS

Spray	Cost	Availability	Storage Life	Notable Characteristics	Comments
1:10 dilution of household bleach	*	Very easily obtained; dilution required	24 hours recommended , but no longer than 30 days	<ul style="list-style-type: none"> - Very short storage life - May damage clothing and other materials with which it comes in contact - Known to cause respiratory distress in some individuals - Generally regarded as safe and not contributing to resistant strains of microbes 	1 part bleach to 9 parts water (approximately ½ cup bleach to 1 quart water or 1.2 dl to a liter. Concentrated bleach varies from 3.25% to 6% and diluted solutions rapidly lose strength in storage.
60-80% isopropyl (rubbing) alcohol	** (US\$2 -3 per quart)	Easily obtained	Most manufacturers will certify to 2 years	<ul style="list-style-type: none"> - Evaporates quickly making 2-5 minute contact time difficult to achieve - Generally regarded as safe and not contributing to resistant strains of microbes 	For this use, 70% IPA is more effective than 90% IPA. Flammable! Store below 120F (50C)
Products containing QUAT	*** (US\$5 -20 per quart)	May be difficult to source (Amazon, Walmart, professional cleaning supply stores, medical supply stores)	Check label - may be greater than 3 years!	<ul style="list-style-type: none"> - Can be unscented but most have added perfumes - QUAT is a salt and is generally regarded as safe and not contributing to resistant strains of microbes 	Some example products are: <ul style="list-style-type: none"> - Diversey Virex® Tb - Clorox® Broad Spectrum QUAT disinfectant



7. Emergency Action Plan (EAP)

Every league should have in place an Emergency Action Plan, which describes what to do in case of the following events.

- Injury requiring medical attention
- Injury requiring Emergency Medical Services
- Fire
- Natural disaster, violence or terrorism requiring emergency evacuation of the facility

The Emergency Action Plan should be tailored to the particular league and facility. In the event a league utilizes multiple facilities, a plan should be developed for each facility.

The Emergency Action Plan shall contain all of the following.

- Include planning for the events listed above.
- Identify Safety Personnel for the league, including the Risk Coordinator, athletes, coaches, Officials, and other volunteers certified in first aid and/or CPR and a method for identifying person(s) responsible for concussion assessment.
- Describe the inventory and location of emergency equipment and supplies (see Appendix E).
- Identify nearby medical facilities equipped for urgent care and emergencies.
- Identify the location of the nearest emergency medical facilities.
- Identify the location of the nearest AED accessible to the public.
- Guidance for the immediate care of the participant based on basic first aid standards or country equivalent
EMS activation

The Emergency Action Plan must be reviewed annually and updated as necessary. The Emergency Action Plan must be communicated to the league.

The following information should be provided to visiting teams prior to arrival and should be posted in a highly visible manner:

- EMS phone numbers (even to confirm 911 is the number)
- The address of the event site (to give to EMS)
- The address and directions of the nearest hospital
- The name and contact information of the Risk Coordinator responsible for the event
- The Emergency Action plan must be provided to the visiting league, medical personnel, and anyone designated as safety personnel for an event

It is suggested that leagues use a format such as [Appendix D: Emergency Action Plan Template](#) to prepare their Emergency Action Plan.

8. WFTDA Insurance Documentation

For events held in the United States:

- **Liability Waivers** are required at ALL TIMES. Participants must sign prior to being permitted to participate.
- Visiting Skaters/volunteers must sign the **Event Waiver** prior to participating, each time they participate (the Event Waiver pertains to an event on a specific date, so a new one must be signed each time a Skater/volunteer visits).
- Members of your league, including volunteers, must sign the **Membership Waiver**, prior to participating. League members sign an electronic version the Membership Waiver when they



obtain WFTDA Insurance online. Skaters trying out must sign the Membership Waiver prior to trying out. Waivers should be kept on file for a minimum of one year.

- **WFTDA Injury Report:** In the event of an injury, the WFTDA Injury Report must be completed and sent to claims@wftda.com within two weeks of the date of injury – even if the injured participant does not intend to file a claim. WFTDA Injury Reports received outside of the allowable reporting grace period will not be eligible for claims. Which injuries should be reported? We recommend that if a jam is called off for an injured participant, or if a participant ceases participation due to an injury, it should be reported, even if the injury appears to be minor.

Outside of the United States, liability waivers should be used as permitted by local law.

If you do not have WFTDA Insurance, please consult with your insurer for all reporting and form requirements.

All WFTDA insurance forms, including injury reports and waivers, can be downloaded from:
<https://www.wftda.org/resources>.



Appendix A: Risk Coordinator Job Description

Leagues must identify a Risk Coordinator who is the primary resource for ensuring league activities meet safety standards.

Functions:

- Meets the expectations of the WFTDA position titled "Risk Coordinator"
- Maintains an up-to-date emergency contact list for active Skaters
- Maintains file drawer of up-to-date Medical History forms for active Skaters (see Appendix C)
- Maintains log of Skater injuries and communicates Skater status to coaches
- Collects Medical Clearance (see Appendix C) forms and communicates Skater status to coaches
- Ensures league WFTDA representative receives WFTDA Injury Reports
- Provides, at minimum, annual training for professional and volunteer safety personnel pertaining to the sideline management of injuries
- Maintains an Emergency Action Plan (EAP) for both practice and game venues
- Develops and adjusts wellness policies as needed by the league
- Ensures clear communication of the wellness policies to all members
- Serves as an advocate for the health and well-being of all Skaters
- Monthly inventory of medical supplies (expiration dates, items used, bandages should be replaced yearly if stored in a non-temperature-controlled space)
- Reviews and ensures compliance with Risk Coordinator Checklist for Games Pre-event
- Familiar with all policies and procedures, including:
 - *WFTDA Risk Management Guidelines*
 - *The Rules of Flat Track Roller Derby* track and safety requirements
 - WFTDA and/or tournament track setup requirements
 - League or event policies

Event Setup

- Conducts a review of the league or event planner's Emergency Action Plan and assigns roles and edit plans as required for the particular event/location.
- Obtains medical staffing per *WFTDA Risk Management Guidelines*.
- Verifies insurance coverage for participating leagues, Skaters, and Officials.
- Downloads and prints copies of the WFTDA Event Waiver and WFTDA Injury Report
- Reviews safety procedures and EAP with all safety staff and game/event managers to ensure readiness.
- Reviews track and venue setup to ensure that the following safety requirements are met:
 - Track setup
 - Medical seating and exit lanes
 - Proper designated zones for track and spectator egress
- Verifies that all medical supplies and ice are available per guidelines.
- Checks in with medical personnel and explain expectations, concussion guidelines, and explanation of roller derby if unfamiliar.
- Makes sure there is a copy of the EAP in each locker room and in medical areas, and copies of the WFTDA Injury Report is available for completion.
- Checks in with game/event manager, Head Officials, and team captains.
- Reviews communication protocols and safety processes with safety staff prior to the start of the event. Ensures that this is communicated to Officials and captains in pre-game meetings.
- Designates a person responsible for cleanup of blood and fluids on the track, and ensure that person has access to the cleanup kit and knows how to use it properly.



During the Event

- Verifies that all medical supplies and ice are available per guidelines.
- Ensures compliance with all track safety requirements by participants and spectators.
- Ensures that adequate medical staff is in place during any warm-ups or gameplay.
In the case of an injury or cleanup, ensures that medical personnel respond quickly and provide support per the EAP protocols.
- In the case of an injury, ensures that the WFTDA Injury Report is completed

Post-event

- Submits completed WFTDA Injury Report(s) to corresponding insurer (as directed on report).
- Reviews medical supplies and replaces any items used during the event.



Appendix B: SCAT5; Concussion Resources

5th International Consensus Statement on Sports Concussion (AKA SCAT5)

SCAT stands for Sports Concussion Assessment Tool and is part of the consensus statement assembled by international experts in Sports Concussion. From the preamble of the most current (5th International Conference):

- The 2017 Concussion in Sport Group (CISG) consensus statement is designed to build on the principles outlined in the previous statements 1–4 and to develop further conceptual understanding of sport-related concussion (SRC) using an expert consensus-based approach. This document is developed for physicians and healthcare providers who are involved in athlete care, whether at a recreational, elite or professional level. While agreement exists on the principal messages conveyed by this document, the authors acknowledge that the science of SRC is evolving and therefore individual management and return-to-play decisions remain in the realm of clinical judgement.
- This consensus document reflects the current state of knowledge and will need to be modified as new knowledge develops. It provides an overview of issues that may be of importance to healthcare providers involved in the management of SRC. This paper should be read in conjunction with the systematic reviews and methodology paper that accompany it. First and foremost, this document is intended to guide clinical practice; however, the authors feel that it can also help form the agenda for future research relevant to SRC by identifying knowledge gaps.

The full text of this document is free and available at: <http://bjsm.bmj.com/content/51/11/838>
McCrory P, Meeuwisse W, Dvořák J, et al, 5th international conference on concussion in sport held in Berlin, October 2016 published in: Br J Sports Med 2017;51:838-847

Also published with the consensus statement are two useful tools, the SCAT5 and the Concussion Recognition Tool:

The **SCAT5** is actually several useful tools including the Glasgow Coma Scale, Maddock's Questions and the Standard Assessment of Concussion (SAC). The SCAT5 may be found at the following link: <http://bjsm.bmj.com/content/bjsports/early/2017/04/26/bjsports-2017-097506SCAT5.full.pdf>

The **CRT** or Concussion Recognition Tool is the 'Pocket' version of the SCAT5, and is the resource of choice for the non-medically trained. It is to be used for the identification of a suspected concussion. It is NOT designed to diagnose concussion. It may be found here: <http://bjsm.bmj.com/content/bjsports/early/2017/04/26/bjsports-2017-097508CRT5.full.pdf>

US Centers for Disease Control (CDC) "Heads Up" Resources

The CDC has assembled and made available on the web a large amount of information and training – most of it geared towards youth sports. Still, the content is applicable and useful at addressing potential concussion in adults.

The basic link for all the programs is here: <https://www.cdc.gov/headsup/index.html>

There is a training for youth coaches here (and is certainly better than no training at all): <https://www.cdc.gov/headsup/youthsports/training/index.html>

If you have any medical background at all, and you like a challenge, work through their Training for Clinician's here, and don't give up until you pass the test: <https://www.cdc.gov/headsup/providers/training/index.html>



CONCUSSION RECOGNITION TOOL 5 ©

To help identify concussion in children, adolescents and adults

RECOGNISE & REMOVE

Head impacts can be associated with serious and potentially fatal brain injuries. The Concussion Recognition Tool 5 (CRT5) is to be used for the identification of suspected concussion. It is not designed to diagnose concussion.

STEP 1: RED FLAGS — CALL AN AMBULANCE

If there is concern after an injury including whether ANY of the following signs are observed or complaints are reported then the player should be safely and immediately removed from play/game/activity. If no licensed healthcare professional is available, call an ambulance for urgent medical assessment:

- Neck pain or tenderness
- Double vision
- Weakness or tingling/burning in arms or legs
- Severe or increasing headache
- Seizure or convulsion
- Loss of consciousness
- Deteriorating conscious state
- Vomiting
- Increasingly restless, agitated or combative

Remember:

- In all cases, the basic principles of first aid (danger, response, airway, breathing, circulation) should be followed.
- Assessment for a spinal cord injury is critical.
- Do not attempt to move the player (other than required for airway support) unless trained to do so.
- Do not remove a helmet or any other equipment unless trained to do so safely.

If there are no Red Flags, identification of possible concussion should proceed to the following steps:

STEP 2: OBSERVABLE SIGNS

Visual clues that suggest possible concussion include:

- Lying motionless on the playing surface
- Slow to get up after a direct or indirect hit to the head
- Disorientation or confusion, or an inability to respond appropriately to questions
- Blank or vacant look
- Balance, gait difficulties, motor incoordination, stumbling, slow laboured movements
- Facial injury after head trauma

STEP 3: SYMPTOMS

- Headache
- "Pressure in head"
- Balance problems
- Nausea or vomiting
- Drowsiness
- Dizziness
- Blurred vision
- Sensitivity to light
- Sensitivity to noise
- Fatigue or low energy
- "Don't feel right"
- More emotional
- More irritable
- Sadness
- Nervous or anxious
- Neck Pain
- Feeling like "in a fog"
- Difficulty concentrating
- Difficulty remembering
- Feeling slowed down
- Feeling like "in a fog"

STEP 4: MEMORY ASSESSMENT

(IN ATHLETES OLDER THAN 12 YEARS)

Failure to answer any of these questions (modified appropriately for each sport) correctly may suggest a concussion:

- "What venue are we at today?"
- "Which half is it now?"
- "Who scored last in this game?"
- "What team did you play last week/game?"
- "Did your team win the last game?"

Athletes with suspected concussion should:

- Not be left alone initially (at least for the first 1-2 hours).
- Not drink alcohol.
- Not use recreational/ prescription drugs.
- Not be sent home by themselves. They need to be with a responsible adult.
- Not drive a motor vehicle until cleared to do so by a healthcare professional.

The CRT5 may be freely copied in its current form for distribution to individuals, teams, groups and organisations. Any revision and any reproduction in a digital form requires approval by the Concussion in Sport Group. It should not be altered in any way, rebranded or sold for commercial gain.

ANY ATHLETE WITH A SUSPECTED CONCUSSION SHOULD BE IMMEDIATELY REMOVED FROM PRACTICE OR PLAY AND SHOULD NOT RETURN TO ACTIVITY UNTIL ASSESSED MEDICALLY, EVEN IF THE SYMPTOMS RESOLVE

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Appendix C: Examples of Return to Play

"In the event a Skater takes leave for medical purposes, they are expected to perform every accessible action for full recovery. Upon their return, the member may or may not be subject to provide written notice from a health care provider, or approval from an appropriate member of the training department. A Skater must fulfill training requirements as set forth in Training Procedure." -Ohio Rollergirls

"Injured Skaters may return to scrimmaging after they have been cleared medically and made up 50% of their total injured time or obtained a note from their physician clearing them for scrimmaging; in this case a shorter amount of time before returning to scrimmaging may be accepted. For example, you are unable to practice for 8 weeks; you must practice for 4 weeks before returning to scrimmage unless you have a note from your physician. If your injury is in excess of 6 months, the Coaches and Captains committee will review your return plan on a case-by-case basis." -Dutchland Derby Rollers

"Skaters are responsible for seeking medical attention for any injury sustained that affects the ability to safely skate and participate in roller derby. Skaters who have sustained serious injuries must be back practicing and fully participating in drills at least 4 weeks prior to competing in an official bout. Serious injuries include but are not limited to fractures, partial or complete ligament tears, concussions, and any medical condition requiring surgery or overnight hospitalization.

This requirement permits the injured Skater to re-enter derby safely and allows the team to get used to skating with the Skater again. Team captains must obtain a formal doctor's note from seriously injured Skaters who are returning to play. The doctor's' note must specify whether the Skater can return to skating with contact or skating without contact. If a captain or coach feels the Skater's health is at risk, then they may ask for more specific clearance from the Skater's medical professional. The doctor's' note will become part of the permanent Skater file maintained by the league. If a Skater, coach, or captain is unsure if an injury qualifies as "serious" or if the injured Skater would like to appeal their situation, they must consult with the Medical Committee lead. In addition to following the advice of a medical professional, please also consider the following factors before returning to skating: full, pain-free range of motion of affected body part; normal or average strength and power of affected body part; no excessive emotional concerns about re-injury; functional stability (no limping or excessive compensation by other parts of the body for the affected body part); relative freedom from pain. Please be aware that re-injury is common when players return to sport before recovery is complete. This may be due to the athlete wanting to return to play, inadequate rehabilitation, or external pressure from other players or coaches. Other injuries may occur due to athletes trying to protect their original injuries and subsequent altered behavior or biomechanics." -Jet City Rollergirls



Example of a Medical Clearance Form

Name of Participant:

Roller derby is a full-contact sport with risks similar to hockey, football, or rugby. The Skater must be able to complete all of the following skills to be able to participate in full contact.

- One-knee/two-knee falls while skating
- Baseball-type slides
- Jump over an object of at least 3 inches
- Can look left, right, and behind quickly without hindrance
- Giving/receiving pushes
- Give/receive hip and shoulder hits

The participant above has medical clearance for the following:

- | | | |
|----------------------------|-----|----|
| 1. Skate only (no contact) | YES | NO |
| 2. Skate with full contact | YES | NO |

Signature of Medical Professional:

Name (printed):

License#:

Address:

Phone#:

Date:

Example of a Medical History Form

Date:

Legal Name:

D.O.B.

Derby Name:

Emergency Contact (name and phone #):

Allergies:

Medical Conditions:

Medications:

(This form should be updated yearly or with changes in condition or medication.)



Appendix D: Emergency Action Plan (EAP) Template

The following is an example of an Emergency Action Plan. Each league shall develop an Emergency Action Plan to suit their particular organization and facilities. Leagues can, and should, tailor an Emergency Action Plan that specifically describes how they will prepare for and manage emergencies. Before creating an Emergency Action Plan from scratch, check with facilities to identify any pre-existing plan they may have in place.

Emergency Action Plan for [league]:

Facility Name:

Facility Address:

Designated Safety Personnel (list names):

Last reviewed and Updated [date]:

Nearest Medical Facility: [Insert address, map, and directions to the nearest urgent care medical facilities.] League Management Facility Contact [name and phone number]:

Facility Office/Management Contact [name and phone number]:

Other Important Contacts [names, titles, phone numbers]:

Emergency Equipment – indicate item and location:

- Fire extinguishers
- AED (Automated External Defibrillator) (if available)

A fully functional and sufficiently stocked first aid kit and an emergency cell phone must be available at all times. All personnel must be aware of this equipment and how it is operated.

Emergency equipment shall include, but is not limited to:

- Copy of League's Emergency Action Plan
- Printed copies of SCAT5 and/or CRT
- First Aid Supplies [insert the list of supplies]. (This list can be used as an inventory check sheet. See Appendix E)

Inventory of the first aid kit will be checked monthly by [designated person]:

All necessary emergency equipment should be on site and within quickly accessible reach of all participants. Our emergency equipment is located [insert location]:

Safety Personnel

All Safety Personnel may be involved as first responders. There are times when the immediate care of an athlete will take place before EMS arrives. Immediate care should be deferred to the most highly qualified Medical Personnel on site.

It is the role of [insert designated person or role] to clear the area so that the injured participant can receive care, until the participant is removed from the track or space.

All Safety Personnel must know the location of emergency equipment and supplies and be prepared to retrieve the required equipment if it is needed.

A designated person should meet EMS personnel close to the site and provide guidance to the exact location of the injured athlete. This person should have keys to locked gates or doors to facilitate entry of EMS personnel.



EMS Activation

Information to provide to the emergency dispatch, such as 911 in the United States, must be posted in clear view in an accessible place. The person calling emergency dispatch should be familiar with the facilities and be able to give clear, accurate information to the phone operator.

- Call 911 (in the United States) for life threatening situations. For non-life-threatening injuries, the consent of the injured person will be needed to activate EMS (assuming they are mentally and physically capable of giving consent).
- When you call 911 from a cell phone, the call often lands in a regional center. A call-taker in a faraway city or county may answer your call. To get help to you, there are two pieces of information the call-taker needs to know immediately:
 - Which city you're calling from
 - What type of emergency you have
- Different emergency services use different dispatch centers. Provide the right information so the call-taker will transfer you to the right center.

Information to Provide When Calling for Emergency Dispatch

- Your name
- Where you are calling from
- Nature of emergency (medical or non-medical)
- Phone number you are calling from
- Number of injured individuals
- The last known condition of the injured individual(s)
- Last known treatment
- Directions to the location
- Tell them someone will meet them at the [insert location of designated place]
- Stay on the line until the dispatcher tells you to hang up

Medical Emergency Protocol

The most highly qualified Medical Personnel on site will evaluate the injured individual and determine the needed course of action. If they deem the injury life threatening or requiring specialized care, EMS will then be activated.

Whenever possible [designated person or role] will accompany the injured individual to the hospital.

Minor, non-critical injuries will be handled as follows:

- Evaluate injury.
- Administer first aid.
- Remove individual from participation if the individual is in a great deal of pain or unable to walk or skate.
- Report the return to play status of injured individual to [name of person or role].
- [designated person or role] will complete the WFTDA Injury Report.

Handling serious injuries:

- Check the individual's level of consciousness, pulse, and breathing.
- Send a contact person to call EMS (911).
- Send someone to wait for the rescue team, help open doors and gates, and direct them to the injured individual.



- Assess the injury: If there is any risk of neck and/or back injury, do not move the person in any way. Wait for EMS.
- Administer first aid. Designate a person to handle crowd control. Assist rescue team in preparing the individual for transport to a medical facility.
- Provide the emergency information to the rescue team.
- Whenever possible, have a person from emergency personnel accompany the individual to the hospital.
- [designated person or role] will complete the WFTDA Injury Report.

Fire and Evacuation Plan

[designated person or role] is responsible for making sure this Emergency Action Plan is kept up to date, practiced, and reviewed periodically. Emergency escape route maps are enclosed and posted at [locations]. [Insert floor plans identifying the location of exits, evacuation routes, manual fire alarm boxes, fire extinguishers, hose stations, fire alarm controls, and sprinkler control valves.]

Evacuation drills are conducted [insert regularity – e.g. annually] by [designated person or role].

In the event that evacuation is necessary, [designated person or role] will announce the evacuation order over the public-address system.

Once evacuated, people will meet at [designated meeting point] for a head count and subsequent instructions.

If that meeting point is not available, the secondary meeting point location is [designated secondary meeting point].

[designated person or role] will serve as the liaison to authorities, and decide when it is "all-clear" to return to the facility.



Appendix E: Recommended Medical Supplies

Basic first aid supplies and a biohazard clean up kit should be available at all locations where skating occurs – practices, scrimmages, games and tournaments. These may be provided by the league, as a function of the venue (e.g. Community Rec or Leisure Centers), or may be provided by the contracted EMS.

First Aid Bag:

- CPR mask
- Splints (arm/leg) (e.g. Roll splint like a SAM splint or equivalent, minimum length 36 inches. Can be cut down if needed)
- Triangular Bandage
- Bandage assortment including:
 - Adhesive bandages
 - Compression wrap (e.g. ACE™ Bandages, Coban™, Vet wrap)
 - Wound closure/suture strips
 - "4x4s" gauze pads (10cm x 10cm gauze pads)
 - Sterile gauze rolls (e.g. Kerlix™)
 - Tape/Pre-wrap
- Wound cleanser (e.g. saline solution, bottle or spray)
- Scissors
- Eye wash
- Antibiotic ointment
- Instant Ice packs or Ice bags in cooler (day-of).
- Petroleum jelly
- Nose plugs

Include the following items in the First Aid bag if the Biohazard Clean-up Kit is packaged or stored separately from the First Aid Bag

- Latex-free gloves
- Paper towels, disposable rags
- Permanent marker
- Sealable disposal bags (e.g. Ziploc®)
- Larger bags for contaminated clothing items

Biohazard Clean-up Kit (must include at minimum, per section 6.1):

- Spray bottle with hard-surface disinfectant (see Blood Borne Pathogens section 6.0)

**

**Note shelf life of hard-surface disinfectant selected for Biohazard Clean-up Kit. 1:10 Bleach solution recommended to be made up the day-of-use and not stored longer than 30 days.

- Paper towels/disposable rags
- Sealable, disposal bags (e.g. Ziploc®)
- Permanent marker
- Disposable gloves

AED

If your facility (practice space, public venue for bouts) doesn't have an AED, it is recommended (not required) that you obtain and maintain one if feasible given your league's resources. There are often local and government agencies that will help with the cost.



Appendix F: Useful Links

Throughout this document are included hyperlinks to web content supplied as resources for more information. The table below is a summary of these links for quick access that were active at the time of publication. Keywords for finding the content are supplied if, over time, these links become broken.

TABLE 5: USEFUL LINKS FOR MORE INFORMATION

Content	Link	Host	Search Keywords
SCAT5: Full article	http://bjsm.bmj.com/content/51/11/838	British Journal of Sports Medicine	Consensus statement on Sport Concussion
SCAT5 Tool	http://bjsm.bmj.com/content/bjsports/early/2017/04/26/bjsports-2017-097506SCAT5.full.pdf		
CRT	http://bjsm.bmj.com/content/bjsports/early/2017/04/26/bjsports-2017-097508CRT5.full.pdf		
Disinfectants for BBP	https://www.cdc.gov/infectioncontrol/guidelines/disinfection/disinfection-methods/chemical.html	USA - Center for Disease Control	CDC chemical disinfection disinfectants
EPA registered Antimicrobial	https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants	USA - Environmental Protection Agency	EPA Registered Antimicrobial; lists C, D, E and F
Extensive Concussion Information and Training	https://www.cdc.gov/headsup/index.html	USA - Center for Disease Control	CDC, Heads Up, Concussion
All WFTDA insurance forms, including injury reports and waivers	https://resources.wftda.org/insurance/	WFTDA	

