School Nurses & Athletic Trainers

The First Line of Defense for Student-Athlete Healthcare

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Three Minutes in September

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History of Inter-disciplinary Collaboration

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Athletic Training 101

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Athletic Training 101

- Domains of Athletic Training Education
  - Injury Prevention
  - Clinical Evaluation & Diagnosis
  - Immediate & Emergency Care
  - Treatment, Rehabilitation & Reconditioning
  - Organization & Administration
  - Professional Responsibility

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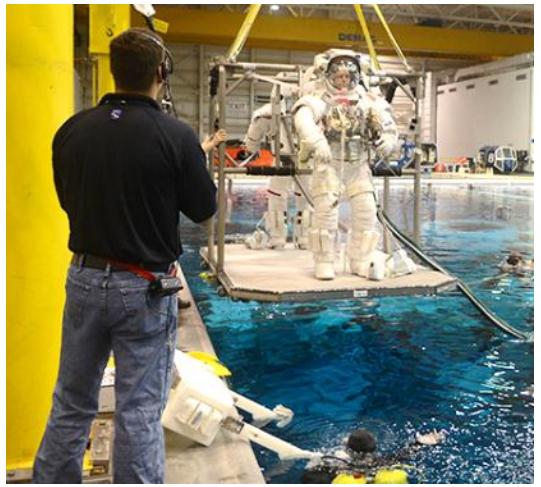
Athletic Training 101 – AT Settings

Performing Arts

Public Safety



Occupational Health

Athletics

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Athletic Training in Indiana

- A Lineage of Leadership in Athletic Training
  - 1998 – Athletic training licensure
  - 2011 – ATs able to receive third party reimbursement for same services as other providers
  - 2014 – ATs included in the list of “healthcare providers” recognized by the state of Indiana
- Continuing Education
  - 50 hours biannually to maintain state licensure
  - National certification is covered with Indiana requirements

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Collaborative Inter-professional Relationships

- Communication
  - HIPAA concerns
  - Provider to provider
  - Provider to parent/guardian
  - Plan of care
- Communication Strategies
  - Early and often
  - Teamwork vs. Turf battles

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Pearls of Evaluation & Treatment from AT

- Upper Extremity
  - Myths & misconceptions
  - Fingers
    - Rugger Jersey Finger

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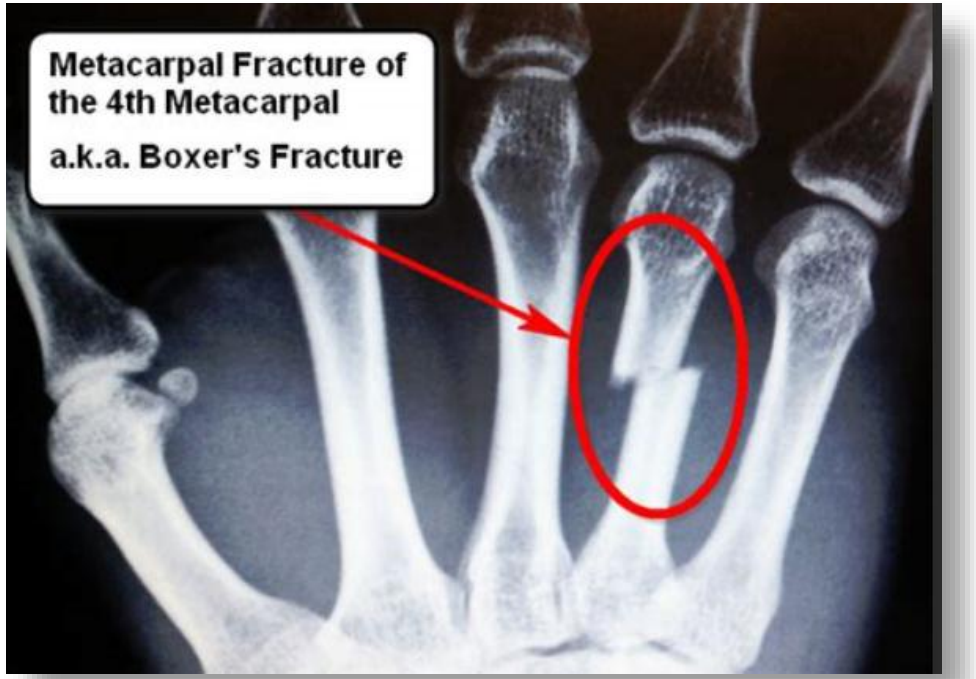
Pearls of Evaluation & Treatment from AT

- Upper Extremity
  - Myths & misconceptions
  - Hand
    - Boxer's Fracture



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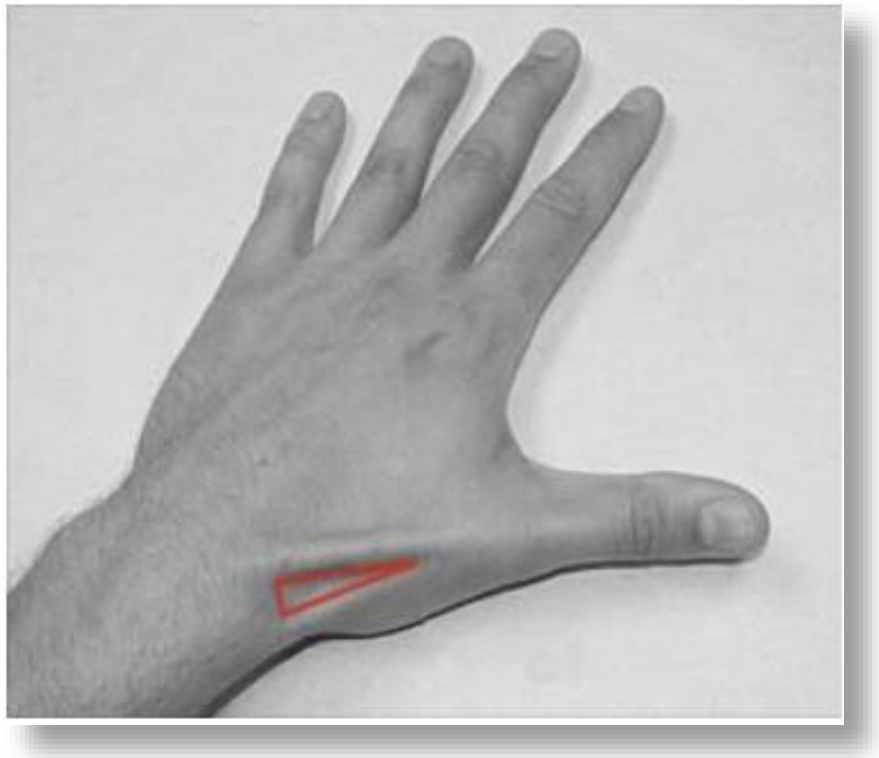
Pearls of Evaluation & Treatment from AT

- Upper Extremity
  - Myths & misconceptions
  - Wrist
    - Navicular/Scaphoid Fracture
    - Anatomical Snuffbox



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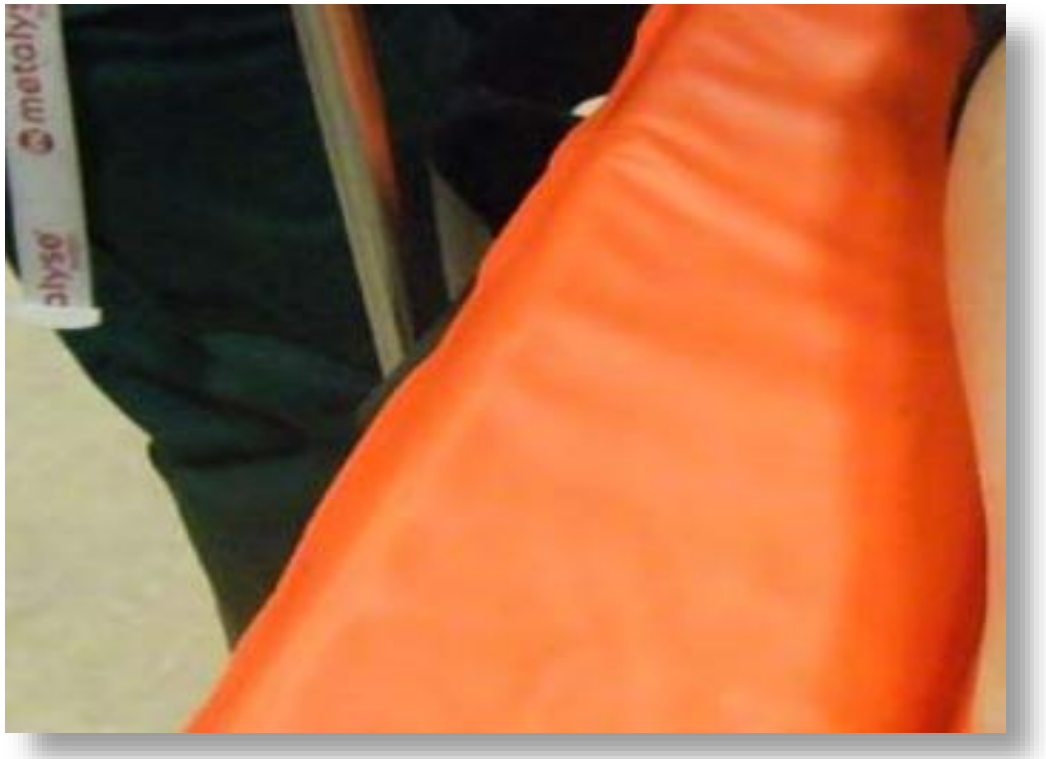
Pearls of Evaluation & Treatment from AT

- Lower Extremity
  - Myths & misconceptions
  - Foot
  - Ankle
    - Dislocation
  - Knee
    - Patellar Dislocation



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Pearls of Evaluation & Treatment from AT

- Sport Related Concussion Management

Table 1 Graduated return-to-sport (RTS) strategy

Stage	Aim	Activity	Goal of each step
1	Symptom-limited activity	Daily activities that do not provoke symptoms	Gradual reintroduction of work/school activities
2	Light aerobic exercise	Walking or stationary cycling at slow to medium pace. No resistance training	Increase heart rate
3	Sport-specific exercise	Running or skating drills. No head impact activities	Add movement
4	Non-contact training drills	Harder training drills, eg, passing drills. May start progressive resistance training	Exercise, coordination and increased thinking
5	Full contact practice	Following medical clearance, participate in normal training activities	Restore confidence and assess functional skills by coaching staff
6	Return to sport	Normal game play	

NOTE: An initial period of 24–48 hours of both relative physical rest and cognitive rest is recommended before beginning the RTS progression.
There should be at least 24 hours (or longer) for each step of the progression. If any symptoms worsen during exercise, the athlete should go back to the previous step.
Resistance training should be added only in the later stages (stage 3 or 4 at the earliest). If symptoms are persistent (eg, more than 10–14 days in adults or more than 1 month in children), the athlete should be referred to a healthcare professional who is an expert in the management of concussion.

Consensus statement on concussion in sport – the 5th international conference on concussion in sport held in Berlin, October 2016.

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Healthcare Professionals

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Thank You!

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