2025

ASAP Safety Manual

for

Managers and Coaches

League ID Number
447-01-05

Mukilteo Little League
P.O. Box 1058
Mukilteo, WA 98275


ASAP
A SAFETY AWARENESS PROGRAM
MUSCO
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CHARACTER
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- **Forms**
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- Insurance Claim Forms
- General Liability Form and Instructions
- Volunteer Application
- Little League Facility Survey
- 2020 Qualified Safety Program Registration Form

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- **Safety Clinic Materials**

2025 Safety Clinics – March 8th 2025. **All managers and coaches in Mukilteo Little League are required to attend one of the safety clinics.**

MISSION STATEMENT

Mukilteo Little League is committed to provide the participants and spectators of the sport of Little League Baseball an environment free from foreseeable hazards.

Mukilteo Little League will provide an environment that promotes the spirit of sportsmanship, teamwork, friendship and respect for each other.

Mukilteo Little League will provide opportunities, through education and information, to increase awareness for creating a safe environment.

BOARD OF DIRECTORS

President	Ed Hansen	847-727-8388	president@mukilteolittleleague.com
Secretary	Chelsea Young	425-457-1407	secretary@mukilteolittleleague.com
Treasurer	Travis Boyd		treasurer@mukilteolittleleague.com
VP Operations	Mark Califano	862-222-6954	vpoperations@mukilteolittleleague.com
Director of Building & Grounds	Mark Califano	862-222-6954	building-grounds@mukilteolittleleague.com
Communications Manager	Sara Taylor	206-518-2209	communications@mukilteolittleleague.com
Registrar	Kurt Doughty	860-573-6533	registrar@mukilteolittleleague.com
Director of Fundraising & Sponsorships	vacant		vpfundraising@mukilteolittleleague.com
Sponsorship Manager	Michael McNany	206-730-3967	sponsorship@mukilteolittleleague.com
Fundraising Manager	Tricia Fox	425-791-0326	fundraising@mukilteolittleleague.com
VP Teenage Baseball	Kevin Bates	425-760-1792	teenagebaseball@mukilteolittleleague.com
Player Agent Teenage Baseball	Kevin Bates	425-760-1792	playeragent-teenagebaseball@mukilteolittleleague.com
VP Baseball Majors/Minors/Farm	Tyler Hagens	206-898-1685	mmfbaseball@mukilteolittleleague.com
Player Agent Baseball Majors/Minors/Farm	Jim Mathews	206-947-2253	playeragentmmf-baseball@mukilteolittleleague.com
VP Rookie/T-Ball	Darin Goodpaster	208-310-3080	rookie-teeball@mukilteolittleleague.com
Player Agent Rookie/T-Ball	Cameron Moffat	425-894-3607	playeragenttbrb-baseball@mukilteolittleleague.com
VP Softball	Shane Carothers	425-530-1961	softball@mukilteolittleleague.com
Player Agent Softball	Jim Tinsley	206-351-7669	playeragent-softball@mukilteolittleleague.com
Umpire in Chief	Jeff Cope	206-395-8871	umpires@mukilteolittleleague.com
Safety Officer	Mike Masella	206-790-9834	safety@mukilteolittleleague.com
Equipment Manager Baseball	Rubin Fir	425-293-5769	equipment@mukilteolittleleague.com
Equipment Manager Softball	Pete Shearer	425-241-6888	equipment-softball@mukilteolittleleague.com
Scheduler Baseball	Mike Harris	206-909-1904	scheduling-baseball@mukilteolittleleague.com
Scheduler Softball	Shane Carothers	425-530-1961	scheduling-softball@mukilteolittleleague.com
Concessions Manager	Mariya Fir	425-530-4799	snackshack@mukilteolittleleague.com
Challenger Division Coordinator	Ed Hansen	847-727-8388	challenger@mukilteolittleleague.com

Training Manager	Shane Patterson	425-737-7179	trainingmanager@mukilteolittleleague.com
Uniform Coordinator	Tracy Lam	323-698-3111	uniforms@mukilteolittleleague.com
Volunteer Coordinator	Kaitlyn O'Donnell	425-387-8340	volunteers@mukilteoittleleage.com
Summer Baseball Coordinator	Darin Goodpaster	208-310-3080	summerball@mukilteolittleleague.com
Fall Ball Coordinator	Shane Patterson	425-737-7179	fallball@mukilteolittleleague.com
Opening Day Coordinator	vacant		

Emergency Phone Numbers

Emergency	**911**
Mukilteo Police Department - Non -emergency:	**(425) 263-8100**
Snohomish County Sheriff's - Non-emergency:	**(425) 388-3393**
Everett Police Department - Non-emergency:	**(425) 257-8400**
Mukilteo Little League Safety Officer **Mike Masella** **Email: safety@mukilteolittleleague.com**	**(206) 790-9834**

CODE OF CONDUCT

- ***Speed Limit 5 mph*** in roadways and parking lots while attending Mukilteo Little League functions. Watch for small children around parked cars.

- ***No alcohol allowed*** in any parking lot, field, or common areas within the complex or schools.

- ***No playing in parking lots*** at any time.

- ***No playing on and around*** lawn equipment and or other facility equipment.

- ***Use crosswalks*** when crossing roadways. Always be alert for traffic.

- ***No profanity***.

- ***No swinging bats*** or ***throwing baseballs*** at any time within the walkways and common areas of the MLL Complex or school facilities.

- ***No throwing balls against dugouts*** or against backstops. Catchers must be used for all batting and pitching practice sessions.

- ***No throwing*** rocks.

- ***No horse play***.

- ***No climbing*** fences.

- ***No pets*** are permitted at the MLL Complex.

- ***Only a player on the field*** and at bat, may swing a bat (ages 5-12). Intermediate, Juniors, and Seniors on the field at bat or on deck may swing a bat. Be alert of the area around you when swinging the bat in the on-deck position.

- ***Observe all posted signs.*** Players and spectators should be ***Alert*** at all times for ***Foul balls*** and ***Errant throws***.

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

- ***After each game, each team must clean up trash*** in dugouts and around stands.

SAFETY CODE

Dedicated to Injury Prevention

- Responsibility for safety procedures should be the responsibility of the Mukilteo Little League Safety Officer. The safety procedures will be provided to Managers / Coaches / Umpires in the form of a Safety Manual. The Safety Officer and a copy of the safety manual will be on file with Little League Headquarters.

- Arrangements should be made in advance of all games and practices for emergency medical services.

- Managers, coaches, and umpires will have basic training in first aid and proper baseball/softball mechanics/fundamentals. This training will be **mandatory** and consist of local Fire Department assistance, medical professionals, league Safety Officer, high school coaches and experienced league coaches at coach's meetings. Baseball clinics are scheduled through the Safety Officer and at least one coach from each team must attend. It is the team managers and coaches' responsibility to pass these fundamentals on to their players.

- Stocked first-aid kits are issued to each team manager prior to the first practice. An additional kit is in the MLL complex concession stand for emergencies. Supplies will be stored and dispensed by MLL to team managers at the league complex on a scheduled basis. It is the responsibility of team managers to keep the first-aid kit stocked. Contact the Safety Officer if supplies run low during the season.

- Each team manager **must** have the first-aid kit at the field during all games and practices.

- Make arrangements to have a cellular phone available when your game or practice is at a facility that does not have any public phones.

- It is the responsibility of each team manager to have a signed medical treatment release form signed by a parent/guardian and kept with the first-aid kit.

- No games or practices should be held when weather or field conditions are not playable, particularly when lighting is inadequate.

- All practices and games **must** have the team manager and one coach in attendance.

- Fields should be inspected frequently for holes, damage, stones, glass and other foreign objects. Manager/Coaches/Umpires are required to inspect fields for hazards before use.

- Coaches must inspect equipment before being used in every game or practice. Worn or damaged equipment should be discarded and reported to the League Equipment Manager(s)

- All team equipment should be stored within the team dugout, or behind screens, and not within the area defined by the umpires as “in play”.

- Only players, managers, coaches, and umpires are permitted on the playing field or in the dugout during games and practice sessions.

- Responsibility for keeping bats and loose equipment off the field of play should be that of a player assigned for this purpose or the team’s manager and coaches.

- Procedures should be established for retrieving foul balls batted out of the playing area.

- During practice and games, all players should be alert and watch the batter on each pitch.

- During warm-up drills players should be spaced so that no one is endangered by wild throws or missed catches.

- All pre-game warm-ups should be performed within the confines of the playing field and not within areas that are frequented by spectators. (i.e., playing catch, pepper, swinging bats, etc.)

- Managers/Coaches/Umpires are required to inspect player’s equipment frequently for the condition of the equipment as well as for proper fit. Replace as needed.

- Batters must wear Little League approved protective helmets bearing the NOCSAE seal during batting practice and games.

- Catchers must wear a catcher's helmet, mask, throat guard, long model chest protector, shin guards and protective cup with athletic supporters at all times for all practice and games. **No exceptions.** Managers should encourage all male players to wear protective cups and supporters for practice and games. It is strongly recommended that female catchers wear a pelvis protector during practices and games**. Catchers in any division in Little League shall not wear SKULL CAPS.**

- Except when a runner is returning to base, head-first slides are **not** permitted. (12 years old and younger)

- While teaching or practicing sliding, all bases should **not** be strapped down or anchored.

- **At no time** should “horseplay” be permitted on the playing field.

- Parents of players who wear glasses should be encouraged to provide “safety glasses”.

- Players must not wear watches, rings, pins or metallic items during games and practices.

- The catcher must wear a catcher’s helmet and mask with a throat guard in warming up pitchers. This applies between innings and in the bullpen during a game and also during practices.

- Managers and coaches may not warm up pitchers before or during a game.

- On-deck batters are not permitted in the Majors Division or lower.

- Players are to wear baseball/softball shoes with rubber cleats molded to the sole or tennis shoes. **(NO STEEL CLEATS ARE ALLOWED, except in the Intermediate, Juniors, and Seniors divisions.)**

- All fields will have bases that disengage from their anchors.

- **ALL INJURIES MUST BE REPORTED TO THE SAFETY OFFICER AS SOON AS POSSIBLE, preferably within 24 hours.**

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See a need to add to the safety code? Contact:

Ed Hansen, President (847) 727-8388

Safety Policies for Mukilteo Little League

Safety Officer's Responsibilities

Within 48 hours of receiving the incident report, the Safety Officer and /or League President 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 (ie., emergency room visit, doctor's visit, etc.) will advise the parent or guardian of Mukilteo Little League's insurance coverages and the instructions for submitting any claims.

If the extent of the injuries is more than minor in nature, the Safety Officer/League President 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 "closed" (i.e., no further claims are expected and/or the individual is participating in the league again).

The Safety Officers will record and track all reported injuries.

Medical Release/ Concussion Compliance Forms

Prior to successful registration, for the upcoming season, all players medical information and concussion compliance acknowledgement is required to be entered into Stack Sports. Once teams are assigned, prior to the first practice, managers must print each team member's Participant Information from Stack Sports and be in possession of these forms at all practices, games, or team outings. It is recommended that these forms be kept in a binder in the equipment bag, or in the first aid kits.

Accident Reporting Procedures

- **What to report-** An incident that causes any player, manager, coach, umpire, volunteer, or spectator to receive medical treatment and /or first-aid must be reported to the ***Safety Officer.*** 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 ***Safety Officer*** *within 48 hours* of the incident. The Safety Officer for 2025 is Mike Masella, and can be reached at the below number:

    - Mike Masella, Safety Officer (206) 790-9834

- **How to make a report-** All incidents **must** be reported to the Safety Officer and the following information **must be provided:**

    - The name and phone number of the individual involved.
    - The Team name and name of the Team Manager.
    - 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 and treatment provided.
    - The name and phone number of the person reporting.

Incident / Injury Tracking Report

All reported injuries will be tracked using the Incident/Tracking Report. A copy of this form is in the "Forms" section of this manual.

Insurance/Liability Claim Forms and Instructions

All forms needed to file a claim can be obtained from the Safety Officer. Copies of these forms are also located in the "Forms" section of this manual.

Volunteer Application Forms/Background Checks

Volunteers such as managers, coaches, umpires, league officers and all elected members are required to complete a Mukilteo Little League approved Volunteer Application Form. This form will contain information consistent with the Little League Volunteer application form. Background checks for each volunteer will be performed during coach and volunteer registration at http://www.mukilteolittleleague.com. A copy of this form is in the "Forms" section of this manual.

Abuse Awareness Training

Beginning with the 2024 Little League regular season, Abuse Awareness Training will be a mandatory part of the Little League Volunteer application and background check. League Volunteers are required to complete Little League Abuse Awareness Training in

accordance with Little League International requirements. No league volunteers shall participate in games and practices prior to completing the Abuse Awareness Training. Upon completion, volunteers shall send a copy of their Abuse Awareness Training Certificate to the League Safety Officer for tracking purposes. Training can be found at LittleLeague.org/training.

“Do’s and Don’ts”

Do…

- Reassure and aid children who are injured, frightened, or lost.
- Provide, or assist in obtaining, medical attention for those who require it.
- Know your limitations.
- Carry your first-aid kit to all games and practices. (A good place to keep *Medical Treatment consent forms*.)
- Assist those who require medical attention – and when administering aid, remember to…
- **LOOK** for signs of injury (Blood, black and blue deformity of joint etc.)
- **LISTEN** to the injured describe what happened and what hurts if conscious. Before questioning, you may have to calm and soothe an excited child.
- **FEEL** gently and carefully the injured area for signs of swelling or grating of broken bone.
- **Make arrangements to have a cellular phone available when your game or practice is at a facility that does not have any public phones.**
- **Have your player’s Medical Treatment Release forms with you at all practice and games.**

Don’t…

- Administer any medications.
- Provide any food or beverages other than water.
- Hesitate in giving first aid when needed.
- Be afraid to ask for help if you are not sure of the proper procedures (i.e., CPR, etc.).
- Transport injured individuals except in extreme emergencies.
- Leave an unattended child at a practice or game.

- ♦ Hesitate to report any present or potential safety hazard to the Safety Officer immediately.

Communicable Disease Procedures

While the risk of one athlete infecting another with HIV/AIDS during competition is close to non-existent, there is the remote risk that other blood borne infectious disease can be transmitted. Procedures for reducing the potential for transmission of infectious agents should include, but not limited to the following:

1. Bleeding must be stopped, the open wound covered and if there is any excessive amount of blood on the uniform it must be changed before the athlete can participate.
2. Routine use of gloves or other precautions to prevent skin and mucous membrane exposure when contact with blood or other body fluids is anticipated.
3. Immediately wash hands and other skin surfaces if contaminated (in contact) with blood or other body fluids. Wash hands immediately after removing gloves.
4. Cleaning all blood contaminated surfaces and equipment with a solution made from a proper dilution of household bleach (CDC) recommends 1-100 or other disinfectant before competition resumes.
5. Practice proper disposal procedures to prevent injuries caused by needles, scalpels and other sharp instruments or devices.
6. Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, or other ventilation devices should be available for use.
7. Athletic trainers/coaches with bleeding or oozing skin should refrain from all direct athletic care until condition resolves.
8. Contaminated towels, gauze, or other disposable products should be disposed of/disinfected properly.
9. Follow acceptable guidelines in the immediate control of bleeding and when handling bloody dressings, mouth guards and other articles containing body fluids.

Lightning Evacuation Procedures

1. Stop the game/practice.
2. Stay away from the metal fencing including dugouts.
3. Do not hold a metal bat.
4. Walk, do not run to a car and wait for a decision on whether or not to continue the game or practice.

Earthquake Procedures

Getting Prepared

The following information is recommended for ballpark structures/concession stands and homes.

1. Securely fasten water heaters and gas appliances
2. Repair defective electrical wiring, leaky gas and inflexible utility connections.
3. Place large or heavy objects on lower shelves. Fasten shelves to walls. Brace high and top-heavy objects.
4. Store bottles, foods, glass, china, and other breakables on low shelves or in cabinets that can fasten shut.
5. Anchor overhead lighting fixtures.
6. Be sure structures are firmly anchored to the foundations.
7. Know where and how to shut off all utilities.
8. Locate safe spots in each structure or room.
9. Identify danger zones in each structure or room.
10. Consider buying earthquake insurance.

When the Ground Moves

1. If indoors – take cover under sturdy furniture or against an inside wall and hold on. **Drop, Cover & Hold**. Stay away from the kitchen.
2. If outdoors – stay there. Move away from buildings, streetlights, field lights and utility wires.
3. In a vehicle – stop as quickly as safety permits and stay in the vehicle. Avoid stopping near or under buildings, trees, overpasses or utility wires.

When the Shaking Stops

1. If the electricity is out – use flashlights or battery powered lanterns.
2. If you smell gas or hear a hissing or blowing sound---open a window and leave the building. Shut off the main gas valve outside.
3. Be prepared for aftershocks.
4. Check for injuries; yourself and those around you.
5. If there is electrical damage – switch off the power at the main control panel.

Travel Hazards

General Accident Prevention

1. In any meeting or gathering where adults are brought together, they should be reminded of their responsibility to:

    a) See that all passengers use seat belts.
    b) Do not carry passengers in cargo areas of vans and pick-ups.
    c) See that their vehicles are in safe operating condition.
    d) Observe traffic regulations.
    e) Drive defensively.

2. Youngsters who are walking to or from the field should be reminded by their parents, managers and coaches to:

    a) Not hitch rides.
    b) Use street or highway crossings protected by lights as much as possible.
    c) Always walk-in single file off the roadway, and on the side against the flow of traffic where there are no sidewalks.
    d) Wear light colored clothing and carry a flashlight when walking along a road after dark.
    e) Be just as alert to the dangers of moving traffic when in a group as when alone. Do not depend on others.
    f) Observe bicycle safety rules as described in the next section.

Bicycle Safety

Managers and coaches should review with players the following bicycle safety points:

- Keep tires inflated and in good condition.
- Always ride single file, one behind the other, with the flow of traffic.
- Do not attempt to hitch a ride at the back of a truck or other vehicle.
- Be careful at intersections and when making turns.
- Use hand signals to make left and right turns, and to slow down or stop.
- If you must ride after dark, use front and rear lights and wear reflective clothing.
- Obey all posted traffic signs, laws, signals, police officers and crossing guards.
- Always wear a sturdy bicycle helmet in good condition.
- Be alert! Watch out for cars, pedestrians, and other bikers.

Basic Bicycle Facts

The bicycle injury death rate among children ages 14 and under declined more than 50 percent between 1987 and 1996. However, bicycles remain associated with more childhood injuries than any other consumer product except the automobile. More than 70 percent of children ages 5 to 14 (27.7 million) ride bicycles. This age group rides about 50 percent more than the average bicyclist and accounts for approximately 30 percent of all bicycle-related deaths and more than 60 percent of all bicycle-related injuries.

Head injury is the leading cause of death in bicycle crashes and is the most important determinant of bicycle-related death and permanent disability. Head injuries account for more than 60 percent of bicycle-related deaths, more than two-thirds of bicycle-related hospital admissions and about one-third of hospital emergency room visits for bicycling injuries. The single most effective safety device available to reduce head injury and death from bicycle crashes is a helmet. Helmet use reduces the risk of bicycle-related death and injury and the severity of head injury when a crash occurs. Unfortunately, national estimates report that bicycle helmet use among child bicyclists ranges from 15 to 25 percent. Helmet usage is lowest (for all ages) among children ages 11 to 14 (11 percent). Bicycle education programs and mandatory bicycle helmet legislation are effective at increasing helmet use and, therefore, reducing bicycle-related death and injury.

DEATHS AND INJURIES

- In 1996, 213 children ages 14 and under died in bicycle-related crashes. Motor vehicles were involved in nearly 200 of these deaths.
- In 1997, more than 350,000 children ages 14 and under were treated in hospital emergency rooms for bicycle-related injuries.
- In 1997, children ages 14 and under accounted for 40 percent of bicyclists injured in motor vehicle crashes. It is estimated that collisions with motor vehicles account for 90 percent of all bicycle-related deaths and 10 percent of all nonfatal bicycle-related injuries. Collision with a motor vehicle increases the risk of death, severity of injury, and probability of sustaining a head injury.
- More than 40 percent of all head injury-related deaths and approximately three-fourths of head injuries occur among children ages 14 and under. Younger children suffer a higher proportion of head injuries than older children.

WHEN AND WHERE BICYCLE DEATHS AND INJURIES OCCUR

- Children are more likely to die from bicycle crashes at non-intersection locations (66 percent), during the months of May to August (55 percent), and between 3 p.m. and 6 p.m. (39 percent).
- Nearly 60 percent of all childhood bicycle-related deaths occur on minor roads. The typical bicycle/motor vehicle crash occurs within one mile of the bicyclist's home.
- Children ages 4 and under are more likely to be injured in non-street locations around the home (driveway, garage, yard) than are children ages 5 to 14.
- Children ages 14 and under are more likely to be injured riding in non-daylight hours (e.g., at dawn, dusk or night). The risk of sustaining an injury during non-daylight conditions is nearly four times greater than during the daytime.
- Among children ages 14 and under, more than 80 percent of bicycle-related fatalities are associated with the bicyclist's behavior including, riding into a street without stopping; turning left or swerving into traffic that is coming from behind; running a stop sign; and riding against the flow of traffic.

- Injuries related to the use of bicycle-mounted child seats typically occur when the bicycle crashes or tips over and when the child falls out of the seat. Falls account for 80 percent of these injuries.

WHO IS AT RISK?

- Riding without a bicycle helmet significantly increases the risk of sustaining a head injury in the event of a crash. Non-helmeted riders are 14 times more likely to be involved in a fatal crash than bicyclists wearing a helmet.
- Collision with a motor vehicle and crashes occurring at speeds greater than 15 miles per hour increase the risk of severe bicycle-related injury and death.
- Children ages 14 and under are five times more likely to be injured in a bicycle-related crash than older riders.
- Males account for more than 80 percent of bicycle-related deaths and 75 percent of nonfatal injuries. Children ages 10 to 14, especially males, have the highest death rate from bicycle-related head injury of all ages.
- Among older children, bicycle injuries sustained by boys are more likely to involve a motor vehicle and occur in a street location than bicycle injuries sustained by girls.
- Children under age 10 are at greater risk for serious injury and are more likely to suffer head injuries than older riders. Approximately half of all bicycle-related injuries among children under age 10 occur to the head/face, compared to one-fifth among older children.
- Bicyclists admitted to hospitals with head injuries are 20 times more likely to die than those without head injuries.

BICYCLE HELMET EFFECTIVENESS

- Bicycle helmets have been shown to reduce the risk of head injury by as much as 85 percent and the risk of brain injury by as much as 88 percent. Bicycle helmets have also been shown to offer substantial protection to the forehead and mid face.
- It is estimated that 75 percent of bicycle-related fatalities among children could be prevented with a bicycle helmet.
- Universal use of bicycle helmets by children ages 4 to 15 could prevent between 135 and 155 deaths, between 39,000 and 45,000 head injuries, and between 18,000 and 55,000 scalp and face injuries annually.
- Child helmet ownership and use increases with income and educational level yet decreases with age. Children are more likely to wear a bicycle helmet if riding with others (peers or adults) who are also wearing one and less likely to wear one if their companions are not.

BICYCLE HELMET LAWS AND REGULATIONS

- Currently, 15 states and numerous localities have enacted some form of bicycle helmet legislation, most of which cover only young riders.
- Various studies have shown bicycle helmet legislation to be effective at increasing bicycle helmet use and reducing bicycle-related death and injury among children covered under the law. Helmet use among children is greater in those regions of the United States with the highest proportion of mandatory helmet laws.
- One example shows that five years following the passage of a state mandatory bicycle helmet law for children ages 13 and under, bicycle-related fatalities decreased by 60 percent.

HEALTH CARE COSTS AND SAVINGS

- The total annual cost of traffic-related bicyclist death and injury among children ages 14 and under is more than $3.4 billion.
- Every dollar spent on a bike helmet saves society $30 in direct medical costs and other costs to society.
- If 85 percent of all child cyclists wore bicycle helmets in one year, the lifetime medical cost savings could total between $109 million and $142 million.
- A review of hospital discharge data in Washington state found that treatment for nonfatal bicycle injuries among children ages 14 and under cost more than $113 million each year, an average of $218,000 per child.

PREVENTION TIPS

- A bicycle helmet is a necessity, not an accessory. Always wear a bicycle helmet every time and everywhere you ride.
- Buy a bicycle helmet that meets or exceeds the safety standards developed by the U.S. Consumer Product Safety Commission federal safety standard or those developed by ANSI, Snell or ASTM.
- Wear a bicycle helmet correctly. A bicycle helmet should fit comfortably and snugly, but not too tightly. It should sit on top of your head in a level position, and it should not rock forward and back or from side to side. The helmet straps must always be buckled.
- Learn the rules of the road and obey all traffic laws. Ride on the right side of the road, with traffic, not against; use appropriate hand signals; respect traffic signals; stop at all stop signs and stop lights; and stop and look both ways before entering a street.

Cycling should be restricted to sidewalks and paths until a child is age 10 and able to show how well he or she rides and observes the basic rules of the road. Parental and adult supervision is essential until the traffic skills and judgment thresholds are reached by each child.

Stranger Danger

All Mukilteo Little League volunteers will adhere and reinforce the following guidelines regarding “strangers”. Managers and coaches will cover *stranger danger* with players.

Do-

- Report all suspicious strangers at practice and game fields to managers and coaches.
- Managers and coaches will stay at fields until parents and/or guardians pick up all players.
- Clearly communicate transportation arrangements.

- Managers and coaches will be alert for suspicious circumstances and notify the authorities when appropriate.
- If players are asked to engage in door-to-door sales for league fund raisers. Parents or an approved adult, should supervise their efforts.

Don't-

- Speak with a stranger.
- Leave the game or practice with anyone other than parents or someone given permission by your parents (prearranged).
- Accept assistance from individuals not affiliated with the Mukilteo Little League.
- Leave players unattended at games or practices. This includes the player's siblings and friends. (This especially has been a problem at the Little League Complex.)

Who Are Strangers?

A stranger is someone you do not know. Even if you recognize people and they act friendly, they are still strangers. The garbage collector, the ice-cream man, and grocery store clerk are all strangers, unless you and your parents have gotten to know their names and addresses and consider them friends of the family. A stranger can be a man, a woman, or a boy or girl, and can be old, young, or in-between. A stranger can wear jeans, a dress, or a suit, and can be any color or nationality. Please see the other pages on this site to know what to do when you see a stranger.

Rules to Follow.

A stranger is anyone you and your family do not know well, and can come in any shape, size, or color.

Stay at least an arm's reach away from a stranger. Back up and run if you feel danger.

Do NOT talk to strangers.

Never take anything from a stranger, not even something that belongs to you.

Never go anywhere with a stranger, no matter what they say.

Do NOT answer requests for help, or personal questions.

If you ever feel like you are in danger, get help from a safe adult, (parent, teacher, friend).

Concession Stand Operations

The Mukilteo Little League has not contracted for concession stand operations for the 2023 season. If a vendor is contracted; the following guidelines will be strictly adhered to.

***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 guidelines will help minimize the risk of food borne illness. This information was provided by District Administrator George Glick and is excerpted from "Food Safety Hints" by the Fort Wayne-Allen County, Ind., 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 and 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 attempt to heat foods in crock pots, steam tables, over sterno units or other 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 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 foodborne 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 exhibits symptoms of sickness or disease (cramps, nausea, fever, vomiting, diarrhea, jaundice, etc.) or who has open sores or infected cuts on their 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. Wash in a four-step process:

1. Washing in hot soapy water.
2. Rinsing in clean water.
3. Chemical or heat sanitizing.
4. 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 foodborne 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 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.

13. Set a Minimum Worker Age.
Leagues should set a minimum age for workers or to be in the stand; in many states this is 16 or 18, due to potential hazards with various equipment.

Mukilteo Little League Fields
Addresses and Phone locations

Field Addresses:	Phone Locations (if any):
Mukilteo Little League Complex 11928 Beverly Park Rd, Everett	None
Kamiak High School 10801 Harbour Pointe Blvd, Mukilteo	Main school buildings
Mariner High School 200 120th St SW, Everett	Next to stadium
Explorer Middle School 9600 Sharon Dr, Everett	None
Harbour Point Middle School 5000 Harbour Pointe Blvd, Mukilteo	None
Olympic View Middle School 2602 Mukilteo Dr, Mukilteo	Next to main office
Voyager Middle School 11711 4th Ave. W, Everett	None
Challenger Elementary School 9600 Holly Dr, Everett	None
Columbia Elementary School 10520 Harbour Pointe Blvd, Mukilteo	None
Endeavour Elementary School 12300 Harbour Pointe Blvd, Mukilteo	None
Fairmont Elementary School 11401 Beverly Park Rd, Everett	None
Mukilteo Elementary School 2600 Mukilteo Dr, Mukilteo	None
Odyssey Elementary School 13025 17th Ave W, Everett	None
Picnic Point Elementary School 5819 140th St. SW, Edmonds	None
Serene Lake Elementary School 4709 Picnic Point Rd, Edmonds	None

Make sure someone at your practice / game has a cellular phone to use!

Mukilteo Little League Facilities

Each year, the Safety Officer shall complete the Little League Facility Survey. All fields used by Mukilteo Little League will have an annual inspection to ensure that facility concerns will be detected and corrected prior to the opening of the Little League season. A copy of the Little League Facility Survey is in the "Forms" section of this manual.

Facility Safety

All coaches and umpires are required to walk each field prior to practice and games inspecting for and removing hazards before use. Items include, but are not limited to rocks, glass, holes, etc.

Equipment Safety

Mukilteo Little Leagues' equipment manager is responsible for annually inspecting equipment before distribution. The equipment manager is also responsible for ordering and replacing equipment to meet Little League International safety requirements. Coaches and umpires have the responsibility to check equipment for safety and report any broken or damaged equipment to the league's equipment manager.

Storage Shed Procedures

The following applies to the storage sheds at the Mukilteo Little League Complex and applies to anyone who has been issued a key by the Mukilteo Little League to use those sheds.

- All individuals with keys to the Mukilteo Little League equipment sheds (ie., Managers, Umpires, etc.) are responsible for the ***orderly and safe storage of rakes, shovels, bases, etc.***

- Before using any machinery located in the sheds (i.e., lawn tractor) please contact the Facilities Manager. Juveniles will not operate motorized equipment.

- All chemicals or organic materials stored in the Mukilteo Little League sheds shall be properly marked and labeled as to its contents. These materials will be stored in areas separate from machinery and tools to minimize the risk of puncturing the containers.

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

- Locked ***Joboxes*** at school fields contain gardening equipment and lime. Care should be used in their use and storage.

Basic First-Aid

Knowing what to do in the first minutes after an emergency has occurred can make a big difference in the outcome. Although this page is no substitute for a formal first aid and CPR course, reviewing this information can help you to be better prepared for that unexpected crisis.

Before we review what you SHOULD do, let us look at a few things you SHOULD NOT do:

1. **Do NOT panic!** You can help a lot more if you remain calm, take a deep breath, and think out your actions!

2. **Do NOT let the victim panic!** (Even if it's you!) Panic increases blood pressure, pulse and respiration which can complicate the medical emergency!

3. **Do NOT forget your own safety**! LOOK at the whole scene! If you get injured, you cannot help anyone!

4. **Do NOT be afraid to ask for help!** Use all the resources you need: neighbors, bystanders, etc. If you remain calm and assume a leadership role in the emergency, most people will be more than willing to listen and help however they can.

The rest of this document will list common medical and trauma emergencies and what you can do until Fire/EMS arrives. Of course, someone will have to call them, so don't forget to review the 911 procedures.

9-1-1 Procedures

If you must call 9-1-1 or the local emergency number. Be prepared to tell:

1. What has happened.
1. Where it has happened
1. Your telephone number.

STAY ON THE LINE until the dispatcher hangs up. If at home, turn on your outside lights to help responders find your home. Also, make sure your house numbers are at least 4 inches tall and visible from the street. Have someone direct responders to the patient. Several vehicles may arrive, depending on where you live.

A , B, C's

For **ALL** Emergencies, quickly assess the patient for:

Airway
Is the airway open or blocked? Is there something preventing the patient from being able to breathe? If there is, you need to Clear the Airway quickly! If it IS clear, make sure it stays that way!

Breathing
Is the patient breathing? If NO, you must act quickly and perform Rescue Breathing! If YES, note the rate and depth. If breathing is slow and/or shallow, you'll need to help them breathe properly.

Circulation
If the patient is unconscious, press two fingers gently against the side of their neck just below the jaw and feel for a pulse. If they're conscious, check there or at their wrist. DO NOT use your thumb to check a pulse, you will feel your OWN pulse! If there's NO PULSE, the patient needs CPR Now! If the pulse is weak and/or rapid, the patient may be going into shock!

Airway Obstructions

There are two ways of clearing an obstructed airway. The method you use depends on whether the patient is CONSCIOUS or UNCONSCIOUS.

UNCONSCIOUS Patients

1. With the patient lying on their back, place two fingers under each side of their jaw and gently push the jaw straight up and out. DO NOT tilt their head back if they have suffered a traumatic injury, i.e., fall, auto-accident, head injury, etc. This maneuver will lift the tongue up and away from the back of their throat.

2. If the patient does not breathe after step 1, try giving them a breath using the Rescue Breathing technique. If you still cannot get any air to go in, go to step 3.

3. Using two fingers slightly bent, start at one side of their mouth and sweep down and out to remove any obstruction from their mouth and upper throat. NEVER use this technique on a CONSCIOUS patient!

1. Attempt step 2 again. If you still cannot get any air in, you need to perform abdominal thrusts to try and force the obstruction out. To do this, straddle the

patient's legs on your knees, facing towards the head. Interlock your fingers with one hand on the other. Place the heel of the bottom hand just above the belly button, then moderately compress the abdomen in an upward direction 8-10 times.

2. Go back to step 2. If the patient is still not breathing and you still cannot get any air to go in, you will need to repeat these steps. A deeply embedded obstruction can be difficult to remove, but failure to remove it will likely result in death!

CONSCIOUS Patients

1. Determine that the patient is choking. The universal signal for choking is a person grabbing their throat. They may still be able to pass some air, in which case you'll hear wheezes as they try to breathe. However, if the patient is able to cough forcefully, DO NOT interfere. Encourage them to continue coughing to force the obstruction out.

1. DO NOT put your fingers or any other object into their mouth! The exception would be if you can visualize the object, but even then, it is not recommended, as you may accidentally push the object farther into their airway.

1. If the patient can stand up, have them do so. You will need to perform the Heimlich Maneuver now.

1. Standing behind and facing the patient, reach your arms around them.

1. Make a fist with one hand and hold it with the other. Place your fist in the middle of their stomach, just above the belly button.

1. In a sharp thrusting motion, press in and upwards to try and force air and the obstruction out of the patient.

1. If the obstruction gets cleared, the patient will usually take a big gasp, which will be your signal that you have successfully saved a choking victim! Monitor the patient for several minutes to make sure they are now able to breathe.

1. If the first thrust fails, you may need to repeat the procedure. Recheck the patient after each attempt.

1. If the obstruction persists, the patient will likely become unconscious, in which case you'll need to continue by treating them according to the UNCONSCIOUS Airway Obstruction method.

Rescue Breathing

Rescue breathing (mouth-to-mouth) is a simple, quick technique that can make the difference between life and death for a non-breathing person. To perform emergency rescue breathing, follow these steps:

1. Make sure the victim's airway is clear, as outlined above.

1. If possible, use a protective device such as a CPR micro shield or pocket mask to protect yourself. A micro shield is located in the team first aid kit.

1. Place yourself beside the victim's head, looking down towards their chest.

1. Ensure the victim's head is in the neutral position, with their neck in a straight line with their back.

1. Place the palm of one hand on their forehead and use your thumb & forefinger to pinch their nose shut.

1. Make a firm seal between the victim's mouth and the protective device or your mouth.

1. Give one steady, full breath, watching their chest to assure that you see the chest rise with the breath.

1. Allow the air to escape naturally from the victim. Repeat this procedure immediately from step 5.

1. After the second breath, look, listen and feel for any spontaneous respiration from the victim.

1. Also, after you give the second breath, check for a pulse! If the victim has no pulse, start CPR promptly!

1. If the victim is not breathing on their own, you need to continue this procedure. A continuous supply of oxygen can greatly reduce the chance for permanent brain damage or death!

Cardio-Pulmonary Resuscitation (CPR)

Managers and coaches need to obtain CPR training. It is beyond the scope and ability of this document to be able to teach CPR properly. To become proficient at CPR requires hands-on practice and personal instruction. CPR can and does save lives every day! Even within the advanced training levels of Paramedics and Doctors, the first and primary step in saving a cardiac arrest victim is CPR!

Managers and Coaches are strongly encouraged to obtain formal CPR certification. Please take the time (usually a 4–8-hour course) to learn the most important life saving skill! A few excellent resources include:

- American Red Cross (Chapters across the US and World)
- American Heart Association (Sponsor courses and private instructors worldwide)
- Your local Fire/EMS department. (Many teach courses or have certified instructors working there)
- Your local hospitals and clinics
- A local college (Many sponsor non-credit short courses in First aid and CPR)

If you are **NOT** certified in CPR, attempting hands-only CPR can be beneficial in saving lives. Quick response time is imperative.

Hand-Only CPR (12 y/o to adult)

1. ***Call 9-1-1 immediately***.
   Ask for an ambulance to respond. If the dispatcher can give you directions for CPR – follow their guidance and ignore the below instructions.

2. ***Push on the chest***.
   Put the heel of your hand directly on the center of the chest, between the nipples. Push down about 1.5 inches at a rate of 100-120 compressions/minute or about 2 per second.

Child CPR (1 – 11 y/o)

1. ***Try to Wake the Child***.
   Tap or shake the child's name attempting to wake them. If the child does not wake call 9-1-1

2. ***Call 9-1-1***
   Ask for an ambulance to respond. If the dispatcher is able to give you directions for CPR – follow their guidance and ignore the below instructions.

3. ***Open Airway and Check for Breathing***

4. ***Give the Child Two Breath***

5. ***Begin Chest Compressions***.
   Place the heel of one hand between nipples. Push straight down about 1.5 inches. Repeat 30 times or about 2 per second.

6. ***Give Child Two Breaths***

If the child does not regain consciousness or resume breathing, repeat steps 4 and 5 until help arrives.

Treatment of Shock

Shock, defined as inadequate tissue perfusion, can occur for a variety of reasons. The most common include blood loss, failure of the heart to pump properly, extreme allergic reaction, and neck/spine injury. Regardless of the cause, there are several symptoms that will indicate the victim is suffering from shock:

- Their mental status/alertness decreases.
- Skin color may be pale. If their color is blue, this indicates a lack of oxygen and Rescue Breathing may be indicated.
- Their pulse may be weak, thready and rapid. They may not even have a pulse at their wrist, so check at their neck for a carotid pulse.
- Squeeze their fingernails and observe the color change. If it takes more than 1-2 seconds for the nailbed to return to pink, this indicates extremity circulation has already begun to shut down.
- Remember, if you can check a blood pressure, that decreased blood pressure is a LATE and serious sign of shock.

Once you have determined or suspect a victim is in shock, there are several things you can do to help reduce the damage of shock and to stabilize them until more help arrives:

- Keep the victim calm and still. DO NOT allow them to move their head/neck as they may have a spine injury.
- Keep the victim insulated. Loss of body heat can result from circulation being routed from the extremities to their vital organs.
- Elevate their feet about 15 degrees, which helps keep the blood closer to vital organs.
- Control any external bleeding by applying direct pressure to the wound.
- Closely monitor their respirations and be prepared to assist if needed using the Rescue Breathing technique.

Specific Emergencies

Vehicle Accidents

Vehicle accidents claim many lives each year, and cause scores of permanent disabilities. Some guidelines to follow if you are first on the scene of an accident include:

- Protect yourself! Watch for traffic and do not assume that because the accident is visible that everyone will use caution. Do not become a victim yourself!

- Check for immediate hazards! Rarely do vehicles explode like in the movies, but the vehicles involved in the accident may be unstable. Make sure the cars are not likely to roll or tip over.

- If you can, set the parking brake of the car and turn off the engine if it is still running.

- Do not allow the patient to move if there is any chance of injury. DO NOT remove the patient from the vehicle unless there is an immediate life-threatening danger.
- Hold and maintain the patient's neck/spine inline by gently placing one hand on each side of their head.

- Calm and reassure the victim. Assess the victim as for all other emergencies.

- If you cannot access the victim because they are entrapped, instruct them to NOT move and stay within easy visual contact of the victim. This will help reassure and keep them calmer.

- If there are several patients, and you do not have any help, remember the rule "Do the most good for the most people."

- Someone who is not breathing or has no pulse is a lower priority than someone who is still breathing but bleeding heavily and going into shock.

Fractures/Dislocations

Although most bone fractures and dislocations are not life threatening, proper treatment and handling of such injuries can enhance full recovery from the injury and lessen the chances for permanent disabilities. The following is a list of guidelines and steps to follow when dealing with bone/joint injuries:

- Remember that bone/joint injuries can be extremely painful, so constantly reassure the victim and keep them calm.

- DO NOT attempt to straighten or unnecessarily move the injured extremity.

- If possible, check for adequate circulation past the area of the fracture by feeling for a pulse. Absence of a pulse past the fracture point is VERY serious and requires prompt hospital attention.

- Immobilize as much of the affected limb as possible, including above and below the fracture, and any joints above or below the fracture. Commonly found items that can be used for splinting include:
    1. Rolled newspaper or magazine
    2. Table/chair leg
    3. Securing a broken arm against the chest
    4. Securing an injured leg to a non-injured leg
- After splinting the injured part, check again to make sure circulation past the injury is still present.

- Ice packs can be used to decrease swelling. However, do not place ice or ice packs directly against the skin, use a towel, cloth, etc. to prevent any tissue damage.
- If a bone end has broken through the skin, DO NOT attempt to move the end back into the skin. Place clean dressings over the open would and splint as above.
- ALWAYS encourage the victim to seek medical treatment for any suspected fracture/dislocation. Failure to have such injuries properly treated can result in partial or complete loss of function.
- Some fractures can be much more serious than others, due to the additional danger of serious internal bleeding. A few of these injuries include:
    1. Pelvic/Hip fractures
    2. Upper leg (Femur) fractures
    3. Rib fractures
    4. Crushing fractures that may sever arteries

- If a neck or back fracture/injury is suspected, NEVER move the patient at all unless there is an immediate life threat from fire, hazardous material, etc. Even then, make every effort to immobilize their neck first!

- To immobilize a neck injury, use a large towel, blanket or similar. Make a large roll and wrap the neck. the wrap need not be tight, just prevent their chin from moving downward. Keep their head in a straight line with their spine. Once you immobilize someone's neck, do NOT leave the victim unattended.

Bleeding Injuries

There are numerous injuries that can result in bleeding, but the rules for treating the bleeding are basically the same. An average adult has between 5 to 6 liters of blood, infants and children much less. Therefore, even a moderate amount of blood loss in small children can be very serious. General guidelines for bleeding control include:

- Protect yourself! Direct blood transfer is the most common means of disease transmission! If possible, wear protective gloves and avoid getting blood splashes in your eyes, mouth, nose!

- Examine the scene! If the injury is a result of violence or hazard, DO NOT endanger yourself! You can do more good by calling for help than by attempting to treat someone and becoming a victim yourself!

- As in all emergencies, keep the victim still and calm. Fear and anxiety increase blood pressure and pulse, which increases the rate of blood loss.

- The preferred method of bleeding control is direct pressure at the site of the bleeding, using towels, sheets, clean cloths, etc. Apply firm pressure directly over the site of the wound.

- Once applied, direct pressure should NEVER be removed. The same goes for any bandages/dressings placed on the wound. If blood begins to soak through the bandaging, ADD MORE bandaging, do NOT remove existing dressings.

- If direct pressure itself does not control the bleeding, find the pulse above the point of bleeding and apply pulse pressure, as well as continuing the direct pressure.

- TOURNIQUETS are very RARELY needed!! This is a last resort technique only. The above two methods can control most all bleeding. In the case of near or total amputation where a tourniquet might be needed, be sure to LET EVERYONE KNOW that a tourniquet is in place, and once applied, only a Doctor should remove the tourniquet.

- The decision to use a tourniquet must be weighed against the very potential loss of extremity below the point of the tourniquet.

- Even if you are sure the bleeding has stopped, DO NOT remove any bandages or dressings. Encourage the victim to seek prompt medical attention, due to the risk of tetanus, infection and permanent scarring.

Seizures

Seizures can have many causes, the most common being epilepsy, heat injury, brain/head injury, overdoses. Again, whatever the cause, there are some do's and don’ts when helping a seizure victim:

- DO NOT try to forcibly restrain or stop the victim from seizing. You can cause more injury.
- Protect the victim during the seizure by removing any obstacles or objects they could be injured from.

- DO NOT put anything in their mouth! It is impossible to swallow the tongue, and serious complications can result of an object gets bit off or otherwise lodged in their airway!

- Watch for vomiting! If the victim begins to vomit, turn them on their side to help avoid inhalation and choking.

- After the seizure, it is normal for the victim to be unresponsive for several minutes. Monitor them closely for respiratory problems, but again, DO NOT put anything in their mouth!

- Check the victim for any medical alert tags, bracelets or chains. You may be able to determine if the victim has a history of seizures.

- Attempt to determine the cause of the seizure, and be prepared to describe what happened before, during and after the seizure.

Chest Pain/Heart Attack

Anyone suffering from chest pain should be evaluated by a Physician as early as possible. Although there are numerous reasons for chest pain, you CANNOT rule out a heart attack without seeing a doctor! There are some specific symptoms of a heart attack, which include:

- Tightness/pressure in center of chest

- Sweaty, clammy skin

- Numbness in one or both shoulders or pain radiating down either or both arms

- Shortness of breath and/or difficulty breathing

- Fear, nervousness or feeling of impending doom

IMPORTANT: A heart attack can be signaled by any or NONE of these symptoms. Just because a person isn't suffering all of the above, does NOT mean they aren't having a heart attack! **When in doubt, seek treatment!**

The best thing you can do for someone suffering from chest pain is to encourage them to seek prompt medical attention! Denial is very common among heart attack victims, so be positive and encouraging, but stern in your insistence that they seek help! The key here is that "TIME IS TISSUE"...the longer the victim waits, the more permanent damage the heart muscle suffers.

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 other Board member immediately. Don't play on a field that is not safe or with unsafe playing equipment. Be sure your players are fully equipped at all times, especially catchers and batters. And check your team's equipment often.

Have a fun and safe season –
"Play ball !!"