Barnes County North Athletic Training Policies and Procedures

Updated March 2016

Applicable to all Varsity Athletics and Student Athletes

General Athletic Training Operations

The Athletic Training Room is a medical facility, please respect the room and athletes present as such.
As licensed medical professionals, Athletic Trainers receive thorough training in preventing, recognizing, and treating critical situations in the physically active.

If you need to use the athletic training room and an athlete is present do not discuss their injury or rehab process with them, regardless if the athlete is on your team. This is against HIPAA (Health Information Privacy Act) regulations.

Coaches please contact the Certified Athletic Trainer if you need an injury update.

Coolers must be clean and put away when they are returned.

Athletes must bring a water bottle to practice/games. Cups are for game use only.

Athletic Trainers will be available **2 hours before competition.**

Athletic Trainer: Alyssa Albrecht, MS, ATC

Student-Athletes are responsible for all medical costs. **All student athletes are recommended to have insurance**

**Game Day Policies and Procedures**

Original home team will have the responsibility of covering the event

The ATC will have the following equipment available for the visiting teams(s):

1. Taping Tables/Area
2. Emergency Splints
3. Crutches

The host institution on game day will also provide:

1. Water
2. Ice chest with bags
3. Biohazard materials
4. Bench towels (volleyball and basketball only)

Visiting teams are responsible for their own athletic training equipment

**Football Game day Policies and Procedures**

1. Supplies available as stated above
2. On-site ambulance required at home football games
3. Physician or Physician Assistant presence suggested, but not required
4. Venue specific Emergency Action Plans are available for visiting teams
**Spinal Injury Procedure**

Sudden death from a cervical spine injury is most likely to occur in football from a fracture-dislocation above the C4 vertebrae.

During initial assessment, the presence of any of the following, alone or in combination, requires the initiation of the spinal injury management protocol:

1. Abnormal level of consciousness or progressive loss of consciousness
2. Obvious swelling or deformity of the spine
3. Spinal pain or tenderness with or without palpation
4. Neurologic signs or symptoms
5. Any doubt concerning injury

**General Guidelines:**
The cervical spine should be in neutral position, and manual cervical spine stabilization should be applied immediately.

Traction MUST NOT be applied to the cervical spine.
Immediate attempts should be made to expose the airway.

If rescue breathing becomes necessary, the person with the most training and experience should establish an airway and begin rescue breathing using the safest technique.
Do not attempt to realign the cervical spine.
Manual stabilization of the head should be converted to immobilization using external devices such as foam head blocks. Whenever possible, manual stabilization is resumed after the application of external devices.
Create as little motion as possible and complete the steps of the EAP as rapidly as is appropriate to facilitate support of basic life functions and prepare for transport to the nearest emergency treatment facility.

**Equipment Removal:**
The removal of helmet and shoulder pads in any equipment intensive sport should be removed immediately by trained personnel.
Those involved in the pre-hospital care of injured football players should have the tools for face mask removal readily available, which is to be done right away.
Prevention

Axial loading is the primary mechanism for catastrophic cervical spine injury. *Head-down contact*, defined as initiating contact with the top or crown of the helmet, is the only technique that results in axial loading.

Both head down contact and spearing are dangerous and may result in axial loading of the cervical spine and catastrophic injury.

Football helmets and other standard football equipment do not cause or prevent axial-loading injuries of the cervical spine. Injuries that occur as a result of head-down contact are technique related and are preventable to the extent that head-down contact is preventable. Instinctively, players protect their eyes and face from injury by lowering their heads at impact. Therefore, coaches must allocate enough practice time to overcome this instinct. Athletes who continue to drop their heads just before contact need additional coaching and practice time.

With the head up the player can see when and how impact is about to occur and can prepare the neck musculature. Initiating contact with the shoulder while keeping the head up is the safest contact position.

The use of videos such as *Heads Up: Reducing the Risk of Head and Neck Injuries in Football* and *Tackle Progressions* can be utilized.

Concussion Procedure

**Definition:**
Concussion is a change in brain function, following a force to the head, which may be accompanied by temporary loss of consciousness, but is identified in awake individuals, with measures of neurologic and cognitive dysfunction.

**Prevention:**
Prevention of concussions will include enforcing the standard use of sport-specific and certified equipment (e.g., National Operating Committee on Standards for Athletic Equipment [NOCSAE]). Educational documents for athletes, parents, coaches, etc. is available at the end of this document and in the Athletic Training room.

**If an athlete displays any signs or symptoms of a concussion they are to immediately be removed from activity and not return until they are evaluated and cleared, in writing, by a medical professional whose scope of practice includes the management and evaluation of concussions.**

**Assessment Tests and Tools:**
The ImPACT program will be utilized by having the athlete complete a baseline exam prior to the start of the season. For all assessment tests and tools (except ImPACT – testing will begin 24 hours
post injury) there will be a baseline test done immediately post injury then reassessed every 5 -10 minutes after than until symptoms clear or athlete is referred. The concussion assessment battery includes a combination of tests for cognition, balance, and self-reported symptoms known to be affected by concussions.

-Standardized Concussion Assessment Tool; SCAT5 (orientation, immediate memory, concentration, months in reverse order, delayed recall) [www.physicians.cattonline.com](http://www.physicians.cattonline.com)

-Balance Error Scoring System

-Serial 7

-Symptom checklist (can include but not limited to: blurred vision, dizziness, drowsiness, lack of concentration, confusion, easily distracted, feel “in a fog” or “slowed down”, headache, inappropriate emotions, irritability, memory problems, nausea, poor balance, ringing in the ears, and sensitivity to light)

-Immediate Post concussion Assessment and Cognitive Testing (ImPACT)

**Treatment:**
If the athlete's symptoms persist or worsen or the level of consciousness deteriorates after a concussion, the patient will be immediately referred to a physician trained in concussion management. Oral and written instructions for home care will be given to the athlete and to a responsible adult (parent, guardian, etc.) who will observe and supervise the athlete during the acute phase of the concussion while at home.

**Return to Activity:**
Returning an athlete to participation after a head injury should follow a graduated progression that begins once the athlete is complete symptom free **and** passing cognitive testing. At a **MINIMUM** the athlete diagnosed with a sport related concussion must be removed from play and must not return to sport related activity for at least one calendar day and are to be evaluated by a health care provider with expertise in sport related concussion.

**The graduated Return-to-Play protocol according to Sanford Health:**

<table>
<thead>
<tr>
<th>Exertion Step</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Light aerobic exercise (walking, stationary cycling; no resistance training) – 10% of maximal exertion</td>
</tr>
<tr>
<td>2.</td>
<td>Mode, duration and intensity-dependent exercise based upon sport - 50% of maximal exertion</td>
</tr>
</tbody>
</table>
3. Sport-specific activity with no head impact – 75% of maximal exertion
4. Non-contact sport drills and resumption of progressive resistance training – maximal exertion
5. Full-contact practice – maximal exertion
6. Return to play

If at any point during the RTP progression, the athletes’ symptoms return, at least 24 hours must pass before the protocol is reintroduced. The athlete must return to the last completed symptom free exertional step in the protocol. An athlete with more than one concussion may take longer to recover and removal from contact sports may be necessary.

**When to Refer an Athlete to a Physician:**
Athletes will be assessed by a physician as necessary after concussion.

Day-of-injury referral

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Protocol Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amnesia lasting longer than 15 min</td>
<td>Athlete is still symptomatic at the end of the game</td>
</tr>
<tr>
<td>Deterioration of neurologic function*</td>
<td></td>
</tr>
<tr>
<td>Decreasing level of consciousness*</td>
<td></td>
</tr>
<tr>
<td>Decrease or irregularity in respirations*</td>
<td></td>
</tr>
<tr>
<td>Decrease or irregularity in pulse*</td>
<td></td>
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<tr>
<td>Increase in blood pressure</td>
<td></td>
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<tr>
<td>Unequal, dilated, or unreactive pupils*</td>
<td></td>
</tr>
<tr>
<td>Cranial nerve deficits</td>
<td></td>
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<tr>
<td>Any signs or symptoms of associated injuries, spine or skull fracture, or bleeding*</td>
<td></td>
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<tr>
<td>Mental status changes: lethargy, difficulty maintaining arousal, confusion, or agitation*</td>
<td></td>
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<tr>
<td>Seizure activity*</td>
<td></td>
</tr>
<tr>
<td>Motor, sensory, balance, or cranial nerve deficits</td>
<td></td>
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<tr>
<td>subsequent to initial on-field assessment</td>
<td></td>
</tr>
<tr>
<td>Post-concussion symptoms that worsen</td>
<td></td>
</tr>
<tr>
<td>Additional post-concussion symptoms as compared with those on the field</td>
<td></td>
</tr>
</tbody>
</table>

*Requires that the athlete be transported immediately to the nearest emergency department.
Delayed referral (after the day of injury)
Any of the findings in the day-of-injury referral category
Post-concussion symptoms worsen or do not improve over time
Increase in the number of post-concussion symptoms reported
Post-concussion symptoms begin to interfere with the athlete's daily activities (i.e., sleep disturbances or cognitive difficulties)

Home Care:
No medication to be taken unless prescribed by the physician. Assume activities of daily living as long as they are symptom free. Athletes should rest as much as possible avoiding stimulants such as movies, video games, television, reading, computers, etc. Also avoid spicy food and alcohol.

Return-to-Learn:
The student athlete may appear physically normal but may be unable to perform as expected in the classroom due to concussive symptomology. A team approach involving the student-athlete, athletic trainer, physicians, coaches, counselors, administrators, and instructors will be utilized to ensure return to academics. It is important the health care providers remain alert to the signs and symptoms of depression and other emotional responses to injury that can be particularly challenging following concussive injury. We will work to prevent or minimize complications of other co-morbidities that may accompany sport-related concussion (e.g. ADHD, migraine or other headache disorders, learning disabilities and mood disorders). If the lights or computer screen aggravate symptoms, individual accommodations will be requested.

Educational Materials:
fs.ncaa.org/Docs/health_safety/ConFactSheetsa.pdf

Psychosocial Problems:
If psychosocial problems arise with a student athlete, they are to be referred to the school counselor.

Inclimat Weather Procedure
In the case of inclimate weather (temperatures, storms, etc.) the Athletic Trainer will have unchallengeable authority to clear a venue or adjust practice times. If an Athletic Trainer is not available the head coach or Athletic Director will monitor.

Lightning may be the most frequently encountered severe-storm hazard endangering physically active people each year. Millions of lightning flashes strike the ground annually in the United States, causing nearly 100 deaths and 400 injuries. Three quarters of all lightning casualties occur between May and September, and nearly four fifths occur between 10:00 am and 7:00 pm, which coincides with the hours for most athletic or recreational activities.
The lightning channel has an average peak current of 20000 A and is 5 times hotter than the surface of the sun.

**Safe Locations:**
In a building with 4 substantial walls, a solid roof, plumbing, and electric wiring – structures in which people live or work or a fully enclosed vehicle, with a metal roof and windows up. If on a school bus during lightening, do not touch the walls of the bus.

**Unsafe Locations:**
Open fields, metal bleachers (or under them), fences, light poles, flag poles, pools or standing water, the highest point of a field or body of water, avoid using plumbing or landline phones during thunderstorm activity.

**Prevention:**
The most effective means of preventing lightning injury is to reduce the risk of casualties by remaining indoors during lightening activity. *Either 6-mile radius; 30-second flash/bang; or “If you hear or see thunder or lightening we are done will 30 minutes after the last strike” are acceptable policies.* Individuals will remain entirely inside a safe building or vehicle until at least 30 minutes have passed since the last lightning strike or the last sound of thunder.

**Prehospital Care:**
Individuals who feel their hair stand on end, skin tingle, or hear crackling noises should assume the lightning-safe position (crouched on the ground, weight on the balls of the feet, feet together, head lowered, and ears covered). Do not lie flat on the ground. Survey the scene for safety. Activate the local EMS system. Evaluate and treat for hypothermia and shock, apnea, asystole fractures, and burns. Most deaths are due to cardiac arrest so be prepared to administer rescue breathing, CPR, or AED. Treat for concussive injuries, fractures, dislocations, and shock.

**Cold Weather Procedure**
Injuries from cold exposure are due to a combination of low air or water temperatures and the influence of wind on the body’s ability to maintain normothermic core temperature, due to localized exposure of extremities to cold air or surface. Environmental factors effecting cold weather injury can include: previous cold weather injury, race, geological origin, ambient temperature, use of medications, clothing attire, fatigue, hydration, age, activity, body size/composition, aerobic fitness level, acclimatization, and low caloric intake.

Frostbite – localized response to cold, dry environment where moisture can exacerbate the
Condition. Frostbite can appear as frostnip, mild frostbite, and deep frostbite.

Prevention:
- Wear proper clothing, dress in layers.
- Stay hydrated, maintain energy levels, and well rested.
- Warm up thoroughly and keep warm throughout the practice or competition to prevent a drop in muscle or body temperature.
- Always have a partner if the weather could cause a cold weather injury/illness.
- As a general rule, the threshold for potentially dangerous wind chill conditions is about minus -20 degrees Fahrenheit.
- Wind chill can accelerate heat loss from exposed skin.

Practice and Competition Sessions:
- 30 degrees Fahrenheit and below: be aware of the potential for cold injury.
- 25 degrees Fahrenheit and below: provide additional protective clothing; cover as much exposed skin as practical; provide opportunities and facilities for re-warming.
- 15 degrees Fahrenheit and below: consider modifying activity to limit exposure or to all more frequent chances to re-warm.
- 0 degrees Fahrenheit and below: consider terminating or rescheduling activity.

No lifts if the wind is higher than 28 MPH; Per OSHA Regulations. Must have safety equipment.

Heat Illness Procedure
- Athletes should be acclimatized to the heat gradually over a period of 7 to 14 days.
- Dehydration:
  - 1%-2% (1.5 - 3 lb. in a 150 lb. athlete) lost body weight causing thirst, irritability, headache, weakness, cramps, nausea, and decreased performance.
  - Dehydration of as little as 2% of body weight has a negative effect on performance and thermoregulation.

Heat Cramps:
- Acute, painful, involuntary muscle contraction caused by dehydration, electrolyte imbalance, or neuromuscular fatigue.

Heat Syncope:
- Also known as orthostatic vasodilatation; usually occurs in the first 5 days of acclimatization; caused by dehydration or lack of adequate blood supply.
causing fatigue, tunnel vision, pale or sweaty skin, decreased pulse rate, dizziness, lightheadedness, or fainting

**Heat Exhaustion:**
- Core body temperature between 99°F to 104°F; causing dizziness, syncope, headache, diarrhea, decreased urine output, persistent muscle cramps, profuse sweating, chills, cool clammy skin, intestinal cramps, weakness, and hyperventilation

**Exertional Heat Stroke:**
- Exertional Heat stroke is classified as a core body temperature of greater than 104°F to 105°F with associated CNS dysfunction. The CNS dysfunction may present as disorientation, confusion, dizziness, vomiting, diarrhea, loss of balance, staggering, irritability, irrational or unusual behavior, apathy, aggressiveness, hysteria, delirium, collapse, loss of consciousness, and coma.
- Most athletes with EHS will have hot, sweaty skin as opposed to the dry skin that is a manifestation of classical EHS

**Treatment Protocol:**
- Remove from activity
- Cold water immersion is the fastest cooling modality. If this is not available, cold water dousing or wet ice towel rotation may be used to assist with cooling.
- Athletes should be cooled first and then transported to a hospital unless cooling and proper medical care is available onsite.
- The water should be approximately 35°F to 59°F and continuously stirred to maximize cooling.

**Return to Play:**
- Once any heat illness has occurred, recurrence is much more likely.
- In all cases of EHS, the athlete must complete a 7 day rest period and obtained normal blood work and physician clearance.
- They may begin a progression of physical activity, supervised by the ATC, from low to high intensity and increasing duration in a temperate environment, followed by the same progression in a warm to hot environment.

**Prevention:**
- Acclimatization, full hydration, planning practices around the warmest times of the day
Hydration Recommendations

- Immediately after practice or competition replace fluids—drink at least 20 oz. of water for every pound of weight loss
- 2-3 hours before exercise drink at least 17-20 oz. of water
- 10-20 minutes before exercise drink another 7-10 oz. of water
- Drink 7-10 oz. of water for every 10 minutes of exercise
- Remember to drink beyond thirst
- Cool beverages (50-59°F) are recommended

- Body weight changes, urine color, and thirst offer cues to the need for rehydration

Sudden Cardiac Arrest

Sudden cardiac death (SCD) is the leading cause of death in exercising young athletes.

Hypertrophic cardiomyopathy and coronary artery anomalies are responsible for approximately 25% and 14% of SCD, respectively.

Through the pre-participation physicals and health history we can recognize a higher risk for this early.

- Personal history:
  - Exertional chest pain/discomfort
  - Unexplained syncope/near syncope
  - Excessive exertional and unexplained dyspnea/fatigue associated with exercise
  - Prior recognition of a heart murmur
  - Elevated systemic blood pressure

- Family history:
  - Premature death (sudden and unexpected, or otherwise) before age 50 years to due heard disease
  - Disability from heart disease in a close relative less than 50 years of age
  - Specific knowledge of certain cardiac condition in family members

- Physical examination:
  - Heart murmur
  - Femoral pulses to exclude aortic coarctation
  - Physical stigmata of Marfan syndrome
  - Brachial artery blood pressure

Sudden cardiac arrest should be suspected in any athlete who has collapsed and is unresponsive. A patient’s airway, breathing, circulation, and heart rhythm (using the AED) should be assessed. An AED should be applied as soon as possible for rhythm analysis. If no pulse is palpable, the patient should be treated for SCA, and CPR should be initiated.

A goal of less than 3-5 minutes from the time of collapse to delivery of the first shock is strongly recommended.
**Skin Conditions**

- This section will describe how the prevention principles will be applied, how infected persons will be identified, and how to communicate information about potentially infected persons to the proper personnel. Skin diseases, especially CA-MRSA are reaching pandemic proportions, so we should be prepared to provide fiscal and human resources for controlling infection in an ever-changing environment.
- Athletes have unique characteristics that make them particularly susceptible hosts. They participate in high-risk activities and have constant assaults to the integrity of their skin making transmission that much easier.
- Combined with the close quarters shared by athletes and generally poor hygiene practices, it is not difficult to see why skin infections cause considerable disruption to individual and team activities.
- **Prevention:**
  - Adequate hygiene materials must be provided to the athletes, including antimicrobial liquid (not bar) soap in the shower and by all sinks.
- **Infection-control policies should be included in an institutions policies and procedure manual.**
- **Custodial staff must be vigilant with following infection control policies.**
- A clean environment must be maintained in the athletic training facility, locker rooms, and all athletic venues. Standard precautions and preventive measures must become the norm in athletic facilities. The adherence to recommended practices can significantly minimize the transmission of infectious diseases.
  - Cleaning and disinfection is primarily important for frequently touched surfaces such as treatment tables, locker room benches, and floors.
- **Athletes must be encouraged to follow good overall hygiene practices.**
  - Athletes must shower after every practice and game with an antimicrobial soap and water. It is preferable for the athletes to shower in the locker rooms provided by the athletic department.
  - Athletes should refrain from cosmetic body shaving.
  - Soiled clothing, including practice gear, undergarments, outerwear, and uniforms, must be laundered on a daily basis.
  - Equipment, including knee sleeves and braces, ankle braces, etc., should be disinfected in the manufacture’s recommended manner on a daily basis.
  - **Hand hygiene is the single most important practice in reducing the transmission of infectious agents.** The correct technique for hand washing includes wetting the hands first, applying an appropriate amount of product, rubbing the hands together vigorously for at least 15 seconds, rinsing the hands with water, and then drying thoroughly with a disposable towel.
- **Athletes must be discouraged from sharing towels, athletic gear, water bottles, disposable razors, and hair clippers.**
- **Athletes with open wounds, scrapes, or scratches must avoid whirlpools and cold tubs.**
Athletes are encouraged to report all abrasions, cuts, and skin lesions to and seek attention from an Athletic Trainer for proper cleansing, treatment, and dressing. All acute, uninfected wounds should be covered with a semi occlusive dressing until healing is complete.

**Bacterial Infections:**
- Athletes with suspicious lesions must be isolated from other team members. All bacterial infections will be referred to a physician for culture and diagnosis. Topical and/or oral antibiotic treatments will begin.
- To return to activity needs to include **ALL** of the following:
  - There should be no new skin lesions for at least 48 hours.
  - After completion of 72 hour course of directed antibiotic therapy.
  - No drainage or exudate from the wound.
  - Active infections may not be covered for competition.

**Fungal Infections:**
- In contact sports, the skin-on-skin contact of the participants and abrasions, both clinical and subclinical, also lend themselves to the passage of fungal infections from one athlete to the next.
- Immediate showering after each training session and thoroughly drying all areas, especially areas where two skin areas may touch or rub together (creases, folds, etc.), is recommended, as well as the use of absorbent sports briefs and the application of bacteriostatic powder.
- Return to activity:
  - Once lesions respond adequately to treatment, generally 3 days of topical treatment in minor cases or 2 weeks of systemic treatment in more severe cases.
  - Athletes with solitary or closely clustered, localized lesions will not be disqualified if the lesions are in a body location that can be covered securely.
  - Lesions that can be covered will be covered with bioclusive followed by pre wrap and stretch tape.
  - Dressings should be changed after each match so that the lesion can air dry.

**Viral Infections:**
- The most common viral infections among athletes are herpes simplex and molluscum contagiosum. Outbreaks of both of these have been known to spread throughout an entire team.
- An individual suspected of having a contagious skin disease should be immediately isolated from other team members until seen by a physician and the infection is properly managed.
- Primary treatment is with antiviral drugs.
- Return to activity:
According to NCAA guidelines, the athlete may not return to participation until he or she has received 5 days of oral antiviral therapy and all lesions have a dried, adhered crust.

### Cleaning Schedules

<table>
<thead>
<tr>
<th>Area</th>
<th>Times Per Day</th>
<th>Times of Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Athletic Training Room (treatment tables, taping tables, and other commonly touched surfaces)</td>
<td>3 times/day</td>
<td>Morning, mid day, and at the end of the day</td>
</tr>
<tr>
<td>Locker rooms (benches, Carpet, other commonly touched surfaces)</td>
<td>Once a day</td>
<td>At the end of the day, once everyone is gone</td>
</tr>
<tr>
<td>Shower rooms in public locker rooms (walls, fixtures, and flooring)</td>
<td>Once a day</td>
<td>At the end of the day, once everyone is gone</td>
</tr>
<tr>
<td>Weight Room (benches, bars, and other commonly touched surfaces)</td>
<td>Once a week</td>
<td>Wednesday mornings</td>
</tr>
</tbody>
</table>

***All areas should be cleaned with a cleaner with bactericide, fungicide, and virucidal efficacy.

### Barnes County North Emergency Action Plan

#### Main and Auxillary Gym

Address: 2192 – 101 Ave SE  Wimbledon, ND 58492

Location of a Landline: Any classroom or main office

Access to gym: Either main front doors or northwest door (#2)

Equipment:

- Red bag with emergency response equipment and oxygen is in the sick room in the main office – during games it is in the northwest corner of the main gym. Spineboard is in the Athletic Training Room. AED is on the ramp outside the southeast door of the gym.
Personnel:

- Head ATC/physician – immediate care of the athlete
- Coach/AT student – assist Head ATC/physician with care / on site documentation
- Coach/student manager (1) – call 911 and remain on the line with the operator
- Emergency Number: 9-9-1-1 (from a landline); 9-1-1 (from a cell phone)
- Phone Location: Any classroom or main office
- Phone Instructions:
  State, "My name is
  State the problem/emergency
  State, “I am calling from Barnes County North School. The phone number is 701-646-6202", or gives cell phone number in case connection is lost.
  State, “My location is in the main/auxiliary gym at BCN”
  Tell emergency personnel to arrive at:
  Main door of BCN or door #2 on Northeast side of school
- Student manager – get emergency equipment
- Student manager/coach/Athletic Director – wait for and direct ambulance and/or control the crowd

** In the absence of an ATC/physician it is campus policy that the coach is head of command, in the presence of an ATC the chain of command is as listed above

Phone numbers:

Sanford Health: (701) 845-6000 (VC); (701) 253-4000 (Jamestown)
Innovis Health: (701) 845-8060 (VC); (701) 253-5300 (Jamestown)
Mercy Hospital Emergency Department: (701) 845-6400
Jamestown Regional Medical Center: (701) 252-1050
Alyssa Sorensen’s number (Head Athletic Trainer): (701) 840-2751

**Once patient has been transported head ATC/physician will do full documentation on events