Protection Guidelines

Definitions

1. The following terms have these meanings in these Guidelines:
    a. “Person in Authority” – An individual who holds a position of authority within the club including, but not limited to, coaches, managers, support personnel, chaperones, and directors
    b. “Vulnerable Participants” – Includes minors and vulnerable adults (people who, because of age, disability or other circumstance, are in a position of dependence on others or are otherwise at a greater risk than the general population of being harmed by people in positions of trust or authority)

Purpose

2. These athlete protection guidelines describe how Persons in Authority can maintain a safe sport environment for athletes.

Interactions between Persons in Authority and Athletes – Rule of Two

3. For interactions between Persons and Authority and Athletes, the club strongly recommends the ‘Rule of Two’ for all Persons in Authority who interact with athletes. The ‘Rule of Two’ is a directive that says that an athlete must never be alone one-on-one with an unrelated Person in Authority.
4. The club recognizes that fully implementing the ‘Rule of Two’ may not always be possible. Consequently, at a minimum, interactions between Persons in Authority and Athletes must respect the following:
    a. The training environment should be open and transparent so that all interactions between Persons in Authority and Athletes are observable
    b. Private or one-on-one situations must be avoided unless they are open and observable by another adult or Athlete
    c. Persons in Authority shall not invite or have an unrelated Vulnerable Participant (or Vulnerable Participants) in their home without the written permission and concurrent knowledge of the Vulnerable Participant's parent or guardian
    d. Vulnerable Participants must not be in any situation where they are alone with an unrelated Person in Authority without another screened adult or Athlete present unless prior written permission is obtained from the Vulnerable Participant’s parent or guardian

Practices and Competitions

5. For practices and competitions, the club and its members recommends:
    a. A Person in Authority should never be alone with a Vulnerable Participant prior to or following a competition or practice unless the Person in Authority is the Vulnerable Participant’s parent or guardian
    b. If the Vulnerable Participant is the first Athlete to arrive, the Athlete’s parent should remain until another Athlete or Person in Authority arrives
    c. If a Vulnerable Participant would potentially be alone with a Person in Authority following a competition or practice, the Person in Authority should ask another

Person in Authority (or a parent or guardian of another Athlete) to stay until all of the Athletes have been picked up. If an adult is unavailable, another Athlete, who is preferably not a Vulnerable Participant, should be present in order to avoid the Person in Authority being alone with a Vulnerable Participant

d. Persons in Authority giving instructions, demonstrating skills, or facilitating drills or lessons to an individual Athlete should always do so within earshot and eyesight of another Person in Authority
e. Persons in Authority and Athletes should take steps to achieve transparency and accountability in their interactions. For example, a Person in Authority and an Athlete who know they will be away from other Participants for a lengthy period of time must inform another Person in Authority where they are going and when they are expected to return. Persons in Authority should always be reachable by phone or text message

Communications

6. For communication between Persons in Authority and Athletes, the club recommends:
    a. Group messages, group emails or team pages are to be used as the regular method of communication between Persons in Authority and athletes
    b. Persons in Authority may only send personal texts, direct messages on social media or emails to individual athletes when necessary and only for the purpose of communicating information related to team issues and activities (e.g., non-personal information)
    c. Electronic communication between Persons in Authority and Athletes that is personal in nature should be avoided. If such communication occurs, it must be recorded and available for review by another Person in Authority and/or by the Athlete's parent/guardian (when the Athlete is a Vulnerable Participant)
    d. Parents and guardians may request that their child not be contacted by Persons in Authority using any form of electronic communication and/or to request that certain information about their child may not be distributed in any form of electronic communications
    e. All communication between Persons in Authority and athletes must be between the hours of 6:00am and midnight unless extenuating circumstances exist
    f. Communication concerning drugs or alcohol use (unless regarding its prohibition) is not permitted
    g. Persons in Authority are not permitted to ask athletes to keep a secret for them
    h. A Person in Authority should not become overly-involved in an athlete's personal life

Travel

7. For travel involving Persons in Authority and Athletes, the club recommends:
    a. Teams or groups of Athlete shall always have at least two Persons in Authority with them
    b. For mixed gender teams or groups of Athletes, there should be one Person in Authority from each gender
    c. Screened parents or other volunteers will be available in situations when two Persons in Authority cannot be present
    d. No Person in Authority may drive a vehicle alone with an Athlete unless the Person in Authority is the Athlete's parent or guardian

e. A Person in Authority may not share a room or be alone in a hotel room with an athlete unless the Person in Authority is the athlete's parent or guardian
f. Room or bed checks during overnight stays must be done by two Persons in Authority
g. For overnight travel when athletes share a hotel room, roommates will be age-appropriate (e.g., within 2 years of age) and of the same gender identity

Locker Room / Changing Area / Meeting Room

8. For locker rooms, changing areas and other closed meeting spaces, the club recommends:
    a. Interactions between a Person in Authority and an individual athlete should not occur in any room where there is a reasonable expectation of privacy such as the locker room, meeting room, restroom, or changing area. A second Person in Authority should be present for any necessary interaction in any such room
    b. If Persons in Authority are not present in the locker room or changing area, or if they are not permitted to be present, they should still be available outside the locker room or changing area and be able to enter the room or area if required

Photography / Video

9. For all photography and video of an Athlete, the club recommends:
    a. Parents/guardians should sign a photo release form (i.e., as part of the registration process) that describes how an athlete's image may be used by the club
    b. Photographs and video may only be taken in public view, must observe generally
    c. accepted standards of decency, and be both appropriate for and in the best interest of the athlete.
    d. The use of recording devices of any kind in rooms where there is a reasonable expectation of privacy is strictly prohibited.
    e. Examples of photos that should be edited or deleted include:
        i. Images with misplaced apparel or where undergarments are showing
        ii. Suggestive or provocative poses
        iii. Embarrassing images

Physical Contact

10. The club understands that some physical contact between Persons in Authority and athletes may be necessary for various reasons including, but not limited to, teaching a skill or tending to an injury. For physical contact, the club recommends:
    a. Unless it is not possible because of serious injury or other circumstance, a Person in Authority should always clarify with an athlete where and why any touch will occur. The Person in Authority must make clear that they are requesting to touch the athlete and not requiring the physical contact
    b. Infrequent, non-intentional physical contact, particularly contact that arises out of an error or a misjudgment on the part of the athlete during a training session, is permitted
    c. Making amends, such as an apology or explanation, is encouraged to further help educate athletes on the difference between appropriate and inappropriate contact
    d. Hugs lasting longer than 5 seconds, cuddling, physical horseplay, and physical contact initiated by the Person in Authority is not permitted. The club is aware that some younger athletes may initiate hugging or other physical contact with a Person in Authority for

various reasons (e.g., such as crying after a poor performance), but this physical contact should always be limited.

Reporting Inappropriate Behaviour & Child Sexual Abuse

11. The following are quick steps for reporting from the Canadian Centre for Child Protection's Commit to Kids Program. This is not meant to be an exhaustive list or replace legal advice. Users are strongly encouraged to consult with any or all of child welfare, law enforcement, and legal counsel as appropriate to a given situation.
    a. *Reporting Inappropriate Conduct*
        i. A child discloses information or information is discovered indicating that a coach/volunteer may have acted inappropriately. Document the information.
        ii. Coach who receives the report notifies the supervisor/manager. Document.
        iii. Manager notifies the head of the organization.
        iv. Consultation between the manager and the head of the organization to decide if concern is warranted. Document.
        v. If warranted, meet with accused coach/volunteer to discuss allegations and concerns. The individual is told about the complaint without disclosing the source. The individual is asked to respond to the allegation. Document.
        vi. If the head of the organization determines that the nature of the conduct is not sufficiently serious to warrant formal action, the organization may choose to clarify expectations with the coach/volunteer as outlined in the Code of Conduct. Document.
        vii. If the head of the organization determines that the nature of the conduct is sufficiently serious to warrant action, an internal follow-up takes place. Document.
        viii. Organization conducts an internal follow up and is documented. Outcomes of the follow up:
            1. ***Inappropriate conduct is not substantiated.*** Follow internal policies. No further action necessary but organization may choose to take the opportunity to remind all coaches/volunteers of the Code of Conduct.
            2. ***Inappropriate conduct is substantiated.*** Next steps will depend on severity of the conduct, the nature of the information gathered during internal follow up, and other relevant circumstances (such as past inappropriate conduct of a similar nature). Varying levels of disciplinary action may be appropriate. For example, it may be prudent for an organization to report concerns to child welfare or law enforcement.
            3. ***Inconclusive.*** Next steps will need to be carefully considered and depend on the nature of the information gathered during the internal follow up. Work through options, assess the risk, and consult professionals as needed.
        ix. Adequately supervise and monitor the coach/volunteer consistent with internal policies. Document.
        x. Note: Consider when/if the child's parents should be notified about allegations of inappropriate conduct.
    b. *Reporting Child Sexual Abuse*

i. Child discloses abuse or abuse is discovered with the adult involved in the abuse being a coach/volunteer. Document the information.
ii. Coach/volunteer who receives disclosure notifies law enforcement and/or child welfare about the incident; consults with child welfare about notifying parents; and notifies the supervisor/manager who in turn notifies the head of the organization. Document.
iii. Head of the organization/manager suspends the coach/volunteer suspected of abuse with or without pay until the case is resolved. Seek legal guidance prior to suspension and/or dismissal. If the individual is a volunteer or unpaid staff, consider if the individual should be dismissed from their position immediately. Document.
iv. A child welfare agency and/or police carry out investigation. Organization should conduct an internal follow up in consultation with police/child welfare and adjust internal policies if needed. Potential outcomes of investigation:
    1. ***Substantiated/guilty.*** Coach/volunteer is dismissed from their position.
    2. ***Inconclusive/not guilty.*** Seek legal counsel. Consider if coach/volunteer should be dismissed, with or without severance.
    3. Note: Criminal processes can be complex and lengthy. A finding of not guilty may not necessarily mean that the abuse did not occur. Consult with a lawyer for this and prior to suspension and/or dismissal.
v. Document the outcome of the investigation on an incident report form. Document the results of the internal follow up.

Deconstructed Concussion Policy

Preamble

1. This Policy is based on the 5th Consensus Statement on Concussion in Sport that was released in April 2017. This Policy interprets the information contained in the report that was prepared by the 2017 Concussion in Sport Group (CISG), a group of sport concussion medical practitioners and experts, and adapts concussion assessment and management tools.
2. The CISG suggested 11 'R's of Sport-Related Concussion ("SRC") management to provide a logical flow of concussion management. This Policy is similarly arranged. The 11 R's in this Policy are:
   Recognize, Remove, Re-Evaluate, Rest, Rehabilitation, Refer, Recover, Return to Sport, Reconsider, Residual Effects, and Risk Reduction.
3. A concussion is a clinical diagnosis that can only be made by a physician. Deconstructed League (the program) accepts no liability for participants or other individuals in their use or interpretation of this Policy.

Definition

4. The following terms have these meanings in this Policy:
    a. "Participant" – Coaches, athletes, volunteers, officials, and other registered individuals

b. “Registered Individuals” – All individuals employed by, or engaged in activities with the Purpose club, including but not limited to, employees, volunteers, administrators, committee members and directors and officers.
c. “Suspected Concussion” – means the recognition that an individual appears to have either experienced an injury or impact that may result in a concussion or who is exhibiting unusual behaviour that may be the result of concussion.
d. “Sport-Related Concussion (“SRC”) – A sport-related concussion is a traumatic brain injury induced by biomechanical forces. Several common features that may be used to define the nature of a SRC may include:
    i. Caused either by a direct blow to the head, face, neck or elsewhere on the body with an impulsive force transmitted to the head.
    ii. Typically results in the rapid onset of short-lived impairment of neurological function that resolves spontaneously. However, in some cases, signs and symptoms evolve over a number of minutes to hours.
    iii. May result in neuropathological changes, but the acute clinical signs and symptoms largely reflect a functional disturbance rather than a structural injury and, as such, no abnormality may be visibly apparent.
    iv. Results in a range of clinical signs and symptoms that may or may not involve loss of consciousness. Resolution of the clinical and cognitive features typically follows a sequential course. However, in some cases symptoms may be prolonged.

Purpose

5. The club is committed to ensuring the safety of those participating in the sport of soccer/football/futbol. The club recognizes the increased awareness of concussions and their long-term effects and believes that prevention of concussions is paramount to protecting the health and safety of Participants.
6. This Policy provides guidance in identifying common signs and symptoms of a concussion, protocol to be followed in the event of a possible concussion and return to participation guidelines should a concussion be diagnosed. Awareness of the signs and symptoms of concussion and knowledge of how to properly manage a concussion is critical to recovery and helping to ensure the individual is not returning to physical activities too soon, risking further complication.

Recognize

7. If any of the following red flags are present, an ambulance should be called and/or an on-site licensed healthcare professional should be summoned:
    a. Neck pain or tenderness
    b. Double vision
    c. Weakness or tingling / burning in arms or legs
    d. Severe or increasing headache
    e. Seizure or convulsion
    f. Loss of consciousness
    g. Deteriorating conscious state
    h. Vomiting
    i. Increasingly restless, agitated, or combative

8. The following observable signs may indicate a possible concussion:
    a. Lying motionless on the playing surface
    b. Slow to get up after a direct or indirect hit to the head
    c. Disorientation or confusion / inability to respond appropriately to questions
    d. Blank or vacant look
    e. Balance or gait difficulties, motor incoordination, stumbling, slow laboured movements
    f. Facial injury after head trauma
9. A concussion may result in the following symptoms:
    a. Headache or “pressure in head”
    b. Balance problems or dizziness
    c. Nausea or vomiting
    d. Drowsiness, fatigue, or low energy
    e. Blurred vision
    f. Sensitivity to light or noise
    g. More emotional or irritable
    h. “Don’t feel right”
    i. Sadness, nervousness, or anxiousness
    j. Neck pain
    k. Difficulty remembering or concentrating
    l. Feeling slowed down or “in a fog”
10. Failure to correctly answer any of these memory questions may suggest a concussion:
    a. What venue are we at today?
    b. Which team is winning?
    c. Which quarter is it?
    d. What team are you playing against?

Remove

11. In the event of a Suspected Concussion where there are observable signs of a concussion, symptoms of a concussion, or a failure to correctly answer memory questions, the Participant should be immediately removed from participation.
12. Participants who have a Suspected Concussion and who are removed from participation should:
    a. Not be left alone (at least for the first 1-2 hours)
    b. Not drink alcohol
    c. Not use recreational/prescription drugs
    d. Not be sent home by themselves
    e. Not drive a motor vehicle until cleared to do so by a medical professional
13. A Participant who has been removed from participation due to a suspected concussion should not return to participation until the Participant has been assessed medically, preferably by a physician who is familiar with the Sport Concussion Assessment Tool – 5th Edition (SCAT5) (for Participants over the age of 12) or the Child SCAT5 (for Participants between 5 and 12 years old), even if the symptoms of the concussion resolve.
14. For Participants who have been removed from participation, the Participant’s parent/guardian should be immediately contacted. The Participant should be isolated in a dark room or area, stimulus should be reduced, the Participant should not be left alone, the Participant should be monitored, and any cognitive, emotional, or physical changes should be documented.

Re-Evaluate

15. A Participant with a Suspected Concussion should be evaluated by a licensed physician who should conduct a comprehensive neurological assessment of the Participant and determine the Participant's clinical status and the potential need for neuroimaging scans.

Rest and Rehabilitation

16. Participants with a diagnosed SRC should rest during the acute phase (24-48 hours) but can gradually and progressively become more active so long as activity does not worsen the Participant's symptoms. Participants should avoid vigorous exertion.
17. Participants must consider the diverse symptoms and problems that are associated with SRCs. Rehabilitation programs that involve controlled parameters below the threshold of peak performance should be considered.

Refer

18. Participants who display persistent post-concussion symptoms (i.e., symptoms beyond the expected timeline for recovery – 10-14 days for adults and 4 weeks for children) should be referred to physicians with experience handling SRCs.

Recovery and Return to Spot

19. SRCs have large adverse effects on cognitive functioning and balance during the first 24-72 hours after injury. For most Participants, these cognitive defects, balance and symptoms improve rapidly during the first two weeks after injury. An important predictor of slower recovery from an SRC is the severity of the Participant's initial symptoms following the first few days after the injury.
20. The table below represents a graduated return to sport for most Participants, in particular those that did not experience high severity of initial symptoms after the following the first few days after the injury.

Stage	Aim	Activity	Stage Goal
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 drills. No head impact activities	Add movement
4	Non-contact training drills	Harder training drills (e.g., defense). 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	

Table 1 – Return to Sport Strategy

21. An initial period of 24-48 hours of both physical rest and cognitive rest is recommended before beginning the Return to Sport strategy.
22. There should be at least 24 hours (or longer) for each step. If symptoms reoccur or worsen, the Participant should go back to the previous step.
23. Resistance training should only be added in the later stages (Stage 3 or Stage 4).
24. If symptoms persist, the Participant should return to see a physician.
25. The Participant's Return-to-Sport strategy should be guided and approved by a physician with regular consultations throughout the process.
26. The Participant must provide the club with a medical clearance form, signed by a physician, following Stage 5 and before proceeding to Stage 6.

Reconsider

27. The 2017 Concussion in Sport Group (CISG) considered whether certain populations (children, adolescents, and elite athletes) should have SRCs managed differently.
28. It was determined that all Participants, regardless of competition level, should be managed using the same SRC management principles.
29. Adolescents (13 to 18 years old) and children (5 to 12 years old) should be managed differently. SRC symptoms in children persist for up to four weeks. More research was recommended for how these groups should be managed differently, but the CISG recommended that children and adolescents should first follow a Return to School strategy before they take part in a Return to Sport strategy. A Return to School strategy is described below.

Stage	Aim	Activity	Stage Goal
1	Daily Activities at home that do not give the child symptoms	Typical activities of the child during the day as long as they do not increase symptoms (e.g., reading, texting, screen time). Start with 5-15 min at a time and gradually build up	Gradual return to typical activities
2	School activities	Homework, reading, or other cognitive activities outside of the classroom	Increase tolerance to cognitive work
3	Return to school part-time	Gradual introduction of schoolwork. May need to start with a partial school day or with increase breaks during the day	Increase academic activities
4	Return to school full time	Gradually progress school activities until a full day can be tolerated	Return to full academic activities and catch up on missed work

Table 2 - Return to School Strategy

Residual Effects

30. Participants should be alert for potential long-term problems such as cognitive impairment and depression. The potential for developing chronic traumatic encephalopathy (CTE) should also be

a consideration, although the CISG stated that “a cause-and-effect relationship has not yet been demonstrated between CTE and SRCs or exposure to contact sports. As such, the notion that repeated concussion or sub concussive impacts cause CTE remains unknown.”

Risk Reduction and Prevention

31. The club recognizes that knowing a Participant’s SRC history can aid in the development of concussion management and the Return to Sport strategy. The clinical history should also include information about all previous head, face, or cervical spine injuries. The club encourages Participants to make coaches and other stakeholders aware of their individual histories.

Non-Compliance

32. Failure to abide by any of the guidelines and/or protocols contained within this policy may result in disciplinary action in accordance with the club’s internal policies.

By signing this Athlete Protection, I acknowledge that I HAVE READ AND FULLY UNDERSTAND AND AGREE TO ALL OF ITS TERMS AND CONDITIONS INCLUDING PERMISSION TO TREAT AGREEMENT. I further state that I have executed this agreement voluntarily and with full knowledge of its significance to be binding on my, my heirs, executors, administrators and assigns.

Participant Printed Name _____ Date of Birth _____

Address _____

Signature _____ Date _____