ECU®

CAMPUS RECREATION AND WELLNESS

CONCUSSION MANAGEMENT PLAN

Last Updated December 7, 2023

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Concussions pose a significant risk to participants at all levels. To increase awareness of concussions in sports and provide recreation employees and participants with the information they need to recognize when to seek help for a suspected concussion, the Assistant Director of Athletic Training in the Campus Recreation & Wellness Department of East Carolina University will institute the following concussion education plan.

Concussion Education Components

Concussion education and awareness materials used by the department will include information on:

- What concussions are
- How concussions happen
- Signs and symptoms
- What to do if a concussion is suspected
- Red flags that necessitate emergency medical care
- The dangers of ignoring a concussion

Who is trained in Concussion Education & Awareness?

- Student staff employed by ECU campus rec & wellness
  - Sport Program Supervisors
  - Facility managers
- All club sport participants

What Is a Concussion?

Sport related concussion (SRC) is a traumatic brain injury (TBI) induced by biomechanical forces. Several common features that may be utilized in clinically defining the nature of a concussive head injury include:

- SRC may be caused either by a direct blow to the head, face, neck or elsewhere on the body with an impulsive force transmitted to the head.
- SRC 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 several minutes to hours.
- SRC 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 is seen on standard structural neuroimaging studies.
- SRC 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.

The clinical signs and symptoms cannot be explained by drug, alcohol, or medication use, other injuries (such as cervical injuries, peripheral vestibular dysfunction, etc.) or other comorbidities (e.g., psychological factors or coexisting medical conditions).

Signs and Symptoms

Recognizing and evaluating SRC in the club participant on the field can be a challenging responsibility for the healthcare provider (i.e. athletic trainer or sports med physician). Performing this task often involves a rapid assessment during competition with a time constraint and the participant eager to play. A standardized objective assessment of injury that excludes more serious injury is critical in determining disposition decisions for the participant. The sideline evaluation completed by the healthcare providers is based on recognition of injury, assessment of symptoms, cognitive and cranial nerve function, and balance. Repeated assessments are often necessary. Because SRC is often an evolving injury, and signs and symptoms may be delayed, erring on the side of caution (i.e., keeping a participant out of participation when there is any suspicion of injury) is important.

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The suspected diagnosis of SRC can include one or more of the following clinical domains:

A. Symptoms: somatic (e.g., headache), cognitive (e.g., feeling like in a fog) and/or emotional symptoms (e.g., lability)
B. Physical signs (e.g., loss of consciousness, amnesia, neurological deficit)
C. Balance impairment (e.g., gait unsteadiness)
D. Behavioral changes (e.g., irritability)
E. Cognitive impairment (e.g., slowed reaction times)
F. Sleep/wake disturbance (e.g., somnolence, drowsiness)

If signs or symptoms in any one or more of the clinical domains are present, an SRC should be suspected, and the appropriate management strategy instituted. It is important to note, however, that these signs and symptoms also happen to be non-specific to concussion, so their presence simply prompts the inclusion of concussion in a differential diagnosis for further evaluation, but the symptom is not itself diagnostic of concussion.

Red Flags - Any person who experiences any of the following after a head injury should seek urgent medical evaluation:

- Significant midline neck pain
- Decreased cervical spine range of motion
- Double vision
- Weakness/tingling/burning in arms or legs
- Severe or increasing headache
- Seizure or convulsions
- Deteriorating conscious state
- Repetitive Vomiting
- Increasingly restless, agitated or combative

Pre-Participation Assessment

Amendment: As of Fall 2022, no more Baseline Testing will be completed due to budget cuts of resources and research stating that baseline testing does not impact the ability to recover or not from a concussion. All previous concussions will be required to be reported on the pre-participation exam or updated on the interim participation exam after their first year as a club member

Event of an Injury

Removal of Participant

If a participant shows any signs or symptoms of an SRC:

i. The participant should be evaluated by a physician or other licensed healthcare provider (i.e., AT) on site using standard emergency management principles, and attention should be given to excluding a cervical spine injury.
ii. The appropriate disposition of the participant must be determined by the treating healthcare provider in a timely manner. If no healthcare provider is available, the participant should be safely removed from practice or play and a referral to an AT +/- a physician arranged.
iii. Once the first aid issues are addressed, an assessment of the concussive injury should be made using the standardized assessment tools.
iv. The participant should not be left alone immediately after the injury, and serial monitoring for deterioration is essential over the initial few hours after injury.
v. A participant with diagnosed SRC should not be allowed to return to play on the day of injury.

Some concussions warrant immediate transportation to a hospital. Emergency personal is needed if the participant begins to experience any of the Red Flags (pg.3). All concussions are to require clearance by a physician

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prior to return to activity and play. Once clearance recommendations have been made, the participant must provide documentation of those clearance recommendations to the ECU CRW AT.

HOME CLUB EVENTS-

A home event is defined as one occurring in the ECU facilities or any of the local satellite facilities

In the event a participant is suspected of having a concussion during a home event they should be removed from play immediately and referred to the athletic trainer covering the game for further evaluation. If the participant is assessed to not have a concussion based off the AT's sideline evaluation, then the participant should be further assessed with exertional maneuvers (pushups, sit ups, mountain climbers, jumping jacks, and jogging). If the participant remains asymptomatic and has no evidence of altered cognitive and/or balance functioning, they may return to play. If a concussion is suspected, then the participant is removed from play for the rest of the game or practice and the participant will follow the ECU CRW ATs medical advice on further instruction. A concussion factsheet will be provided to the participant by the Athletic Trainer, Sport Program Supervisor or Facility Manager via email or hard copy. All concussions will require a follow up with a physician. Any participants with a concussion will be referred to a physician as soon as available.

If the AT is not present at the time of injury, they should be notified as soon as possible by a Club Officer. Participants who have been removed from play and not assessed immediately by an AT should get in contact with the ECU CRW ATs to be evaluated as soon as available.

AWAY CLUB EVENTS –

An away event is defined as one occurring outside of the ECU Facilities or satellite locations.

In the event of a participant being suspected of sustaining a head injury during an away event, the participant should be immediately removed from play and should not be allowed to return. If an AT is available at the hosting facility, the participant should seek care from the hosting AT or medical personnel. If no AT or medical personnel is present at the venue, designated team safety officers should run the participant through the provided CRT-6 (See Appendix B) assessment too. The participant should be monitored closely, and the ECU CRW ATs should be informed immediately by a Club Officer. Within 24 hours of the teams return, the participant must follow-up with the ECU CRW AT for further instruction.

INTRAMURAL EVENTS

In the event of a participant being suspected of sustaining a head injury during an intramural event, the participant should be immediately removed from play and should not be allowed to return. Student staff should radio an AT to inform them there is a suspected head injury. Student staff will bring the injured participant to the AT if possible. A concussion factsheet will be provided to the participant by the Athletic Trainer, Sport Program Supervisor or Facility Manager via email or hard copy. If no AT is present, a sport program supervisor is to fill out an accident report and review the CRT-6 with the participant. The participant should be given the business card of the ATs and informed that they will need to schedule an appointment with an AT before returning to participation.

OPEN RECREATION

Any open recreation participant suspected of sustaining a head injury between 3:00-PM – 7:00 PM Monday through Thursday should be brought to the Athletic Training room for evaluation. While they are waiting to be seen

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by an AT, the student staff should be filling out an accident report located in CRW Internal Links. All other head injuries that occur outside that time window should be brought to the Facility Manager to be assessed using the CRT-6. Facility Manager will provide them with a concussion factsheet, inform them that they are no longer allowed to participate until evaluated by the CRW ATs and that the CRW AT's will reach out to them to schedule a follow up evaluation to determine their ability to return to participation or not.

Post-Concussion Treatment Plan

Referral

Participants suspected of having an SRC or other TBI will be referred for evaluation by a medical professional with concussion experience. They will be suspended from IM Leagues, facility access and will not be allowed to start the return to play progression until they provide the ECU CRW ATs with documentation of clearance from a physician. The injured participant needs to follow up with the AT regularly to monitor symptoms. If the participant does not follow treatment plan accordingly, they put their club at risk for a 1-year suspension. See Club Sports Handbook for more details.

Return to Play (RTP) Progression

After an appropriate initial evaluation and a brief period of rest during the acute phase (24–48 hours) after injury, club participants can be encouraged to become gradually and progressively more active while staying below their cognitive and physical symptom-exacerbation thresholds (i.e., activity level should not bring on or worsen their symptoms) under the supervision of their AT. It is reasonable for participants to avoid vigorous exertion while they are recovering. There should be at least 24 hours (or longer) for each step of the progression. If any symptoms worsen during exercise, the participant should go back to the previous step. Closely monitored active rehabilitation programs involving controlled sub-symptom-threshold, submaximal exercise has been shown to be safe and may be of benefit in facilitating recovery. Resistance training should be added only in the later stages (stage 3 or 4 at the earliest). Refer to Figure 1 (pg. 5) for more information.

Club sport participants will be required to go through their RTP while supervised by an ECU CRW AT. Intramural and open recreation participants will be given a concussion factsheet (See Appendix C) as well as the progression chart (Figure 1, pg. 5) to complete their progression on their own. After it's been completed, they will return to the ECU CRW ATs for a final check-in before clearance to return to activity. RTP guidelines for each sport can be found in the Concussion Return to Play Sport Specific Guidelines Handbook.

6-Step Return to Play Progression Chart

Figure 1

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

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

Follow the link below for further progression recommendations from the CDC
https://www.cdc.gov/headsup/basics/return_to_sports.html

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Return to Learn

In most cases, a concussion will only transiently limit a student's participation in school; however, in some cases, a concussion can affect multiple aspects of a student's ability to participate, learn, and perform well in school. In turn, the experience of learning and engaging in academic activities that require concentration can cause a student's concussion symptoms to reappear or worsen. The concept of resting the brain is important and it is recommended to limit brain exertion with activities such as thinking, learning, memorizing, reading, texting, computer time, and watching TV for at least the first 24-48 hours following a concussion. A gradual return to cognitive activities, if it does not make things worse, is the best approach.

If a participant is having difficulties focusing or being able to fulfill their academic responsibilities due to concussion symptoms, the participant should contact the Assistant Director of Athletic Training to set up a follow-up appointment with the Sports Medicine Physician on campus. If the Sports Med Physician feels the participant needs academic accommodations, they will refer them to accessibility services on campus. At Student Accessibility Services, an access consultant will meet one-on-one with the student to assess their level of disability and create a customized plan for accommodations.

Figure 2

Graduated Return to School Strategy Chart

Table 2 Graduated return-to-school strategy

Stage	Aim	Activity	Goal of each step
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 (eg, 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 increased 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

Reinstatement

After the RTP has been completed the AT deems the participant safe to return to activity, and the physician has not requested a follow up before their return, the AT will unsuspend the participant from IM Leagues and Fusion. This will allow them to participate in intramural sports and regain access to the facilities. Only the ATs can give them this access again when the suspensions are due to injuries.

Recordkeeping

It is essential that the department keep records of accidents and incidents that happen, including those involving a concussion. If a participant is suspected of sustaining a concussion, an accident report should be completed as soon as possible and should record all signs and symptoms observed or experienced. Make sure to include complete contact information for the injured participant, record what type of assessment was performed, what type of treatment was provided, and any instructions that were given for follow-up. Initial accident reports will be input in the Accident Report form located in CRW Internal Links and the ATs injury evaluation will be input to Healthy Roster. The AT's, Senior Assistant Director of Sport Programs, Assistant Director of Sport Programs and the Associate Director of Leadership & Programs have access to the Accident Reports. Only the Athletic Trainers have access to the reports on Healthy Roster.

Review of Plan

Our understanding of concussions is constantly evolving. This plan was written to be in alignment with the most recent international consensus statement on concussion in sport and best practices for concussion management. The plan will be reviewed annually and updated as appropriate to stay in line with current recommendations.

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Appendix A – Risk Classification of Club Sports

Club Sport Coverage & Risk Level Classifications

(AT= Athletic Training, ATR = Athletic Training Room, ATC= Certified Athletic Trainer, ECU CRW= East Carolina University Campus Recreation & Wellness, ESRC = Eakin Student Recreation Center.)

High Risk *(Contact & Collision)*	Moderate Risk *(Contact)*	Low Risk *(Limited Contact)*
1. Rugby (M) 2. Ice Hockey (M) 3. Rugby (W) 4. Lacrosse (M) 5. Wrestling 6. Cheerleading 7. Soccer (M) 8. Soccer (W) 9. Lacrosse (W)	10. Volleyball (M) 11. Volleyball (W) 12. Field Hockey 13. Baseball 14. Softball 15. Ultimate Frisbee (M) 16. Ultimate Frisbee (W) 17. Martial Arts 18. Equestrian	19. Swimming 20. Tennis 21. Olympic Weightlifting 22. Dance 23. Figure-Skating 24. Sporting Clays* 25. Cross Country/Track 26. Rock Climbing

General AT Coverage Expectations: During weeknight practices, one athletic trainer will be stationed in the ESRC ATR from 3:00 – 8:00 PM, and 1 athletic trainer will check in on High-Risk club sport scheduled to practice each night. CRW Athletic Trainers will not travel with teams, the team's safety officers are expected to contact ECU CRW athletic training staff immediately if there are any concussions or injuries that require additional evaluation by healthcare providers. All other injury reports should be completed/submitted within 24 hours of injury. ATC will not provide sideline coverage at non-contact/walk through practices, and the teams will need to communicate before 3:00PM day of practice when they plan to have non-contact/walk through practices.

High Risk: These clubs will have sideline AT coverage for games and competitions. When ATC coverage is available, the priority is given to the sport that is higher up on the list. If ECU CRW athletic training staff is unable to accommodate schedule, coverage from a contracted outside source will be provided. To guarantee sideline athletic training coverage, events should be submitted 14 days in advance, preferably the more advance notice, the better.

Moderate Risk: These clubs will not be checked in on during practice times regularly, but they can request a drop in if needed. These teams have the option to request sideline athletic training coverage for their games, events, or competitions. Their request must be given at least 14 days in advance. The ECU athletic training staff has the option to accept or deny request within 5 days of the event based on availability.

Low Risk: These teams will not receive any sideline athletic training coverage but do have access to the rehab services provided in the clinic during operating hours.

Appointments: To schedule an appointment with the athletic training staff you can use our online booking system.

To categorize each sport, the teams risk assessment was based off research provided by NCAA Sports Medicine Handbook, NATA Position Statements, CDC and Guideline 21 that includes injury rates per athlete exposures, classifications of sports by contact and rate of concussion in competitions.

Modifications may be made to this document as ECU CRW ATC/Physician deem necessary.

Last revised July 19, 2023 by Jennifer Pidgeon

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Appendix B – Concussion Recognition Tool (CRT-6)

Br J Sports Med: first published as 10.1136/bjsports-2023-107021 on 14 June 2023. Downloaded from http://bjsm.bmj.com/ on December 7, 2023 at Laupus Health Sciences Library, East Carolina University. Protected by copyright.

What is the Concussion Recognition Tool?

A concussion is a brain injury. The Concussion Recognition Tool 6 (CRT6) is to be used by non-medically trained individuals for the identification and immediate management of suspected concussion. It is not designed to diagnose concussion.

Recognise and Remove

Red Flags: CALL AN AMBULANCE

If **ANY** of the following signs are observed or complaints are reported after an impact to the head or body the athlete should be immediately removed from play/game/activity and transported for urgent medical care by a healthcare professional (HCP):

- **Neck pain or tenderness**
- **Seizure, 'fits', or convulsion**
- **Loss of vision or double vision**
- **Loss of consciousness**
- **Increased confusion or deteriorating conscious state (becoming less responsive, drowsy)**
- **Weakness or numbness/tingling in more than one arm or leg**
- **Repeated Vomiting**
- **Severe or increasing headache**
- **Increasingly restless, agitated or combative**
- **Visible deformity of the skull**

Remember

- In all cases, the basic principles of first aid should be followed: assess danger at the scene, check airway, breathing, circulation; look for reduced awareness of surroundings or slowness or difficulty answering questions.
- Do not attempt to move the athlete (other than required for airway support) unless trained to do so.
- Do not remove helmet (if present) or other equipment.
- Assume a possible spinal cord injury in all cases of head injury.
- Athletes with known physical or developmental disabilities should have a lower threshold for removal from play.

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If there are no Red Flags, identification of possible concussion should proceed as follows:

Concussion should be suspected after an impact to the head or body when the athlete seems different than usual. Such changes include the presence of **any one or more** of the following: visible clues of concussion, signs and symptoms (such as headache or unsteadiness), impaired brain function (e.g. confusion), or unusual behaviour.

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Appendix B – Concussion Recognition Tool (CRT-6)

Concussion Recognition Tool 6 - CRT6™

CRT6 Concussion Recognition Tool

To Help Identify Concussion in Children, Adolescents and Adults

1: Visible Clues of Suspected Concussion

Visible clues that suggest concussion include:

- Loss of consciousness or responsiveness
- Lying motionless on the playing surface
- Falling unprotected to the playing surface
- Disorientation or confusion, staring or limited responsiveness, or an inability to respond appropriately to questions
- Dazed, blank, or vacant look
- Seizure, fits, or convulsions
- Slow to get up after a direct or indirect hit to the head
- Unsteady on feet / balance problems or falling over / poor coordination / wobbly
- Facial injury

2: Symptoms of Suspected Concussion

Physical Symptoms
Headache
"Pressure in head"
Balance problems
Nausea or vomiting
Drowsiness
Dizziness
Blurred vision
More sensitive to light
More sensitive to noise
Fatigue or low energy
"Don't feel right"
Neck Pain

Changes in Emotions
More emotional
More Irritable
Sadness
Nervous or anxious

Changes in Thinking
Difficulty concentrating
Difficulty remembering
Feeling slowed down
Feeling like "in a fog"

Remember, symptoms may develop over minutes or hours following a head injury.

3: Awareness

(Modify each question appropriately for each sport and age of athlete)

Failure to answer any of these questions correctly may suggest a concussion:

"Where are we today?"

"What event were you doing?"

"Who scored last in this game?"

"What team did you play last week/game?"

"Did your team win the last game?"

Any athlete with a suspected concussion should be - IMMEDIATELY REMOVED FROM PRACTICE OR PLAY and should NOT RETURN TO ANY ACTIVITY WITH RISK OF HEAD CONTACT, FALL OR COLLISION, including SPORT ACTIVITY until ASSESSED MEDICALLY, even if the symptoms resolve.

Athletes with suspected concussion should **NOT**:

- Be left alone initially (at least for the first 3 hours). Worsening of symptoms should lead to immediate medical attention.
- Be sent home by themselves. They need to be with a responsible adult.
- Drink alcohol, use recreational drugs or drugs not prescribed by their HCP
- Drive a motor vehicle until cleared to do so by a healthcare professional

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Appendix C – ECU CRW Concussion Factsheet

ECU CRW CONCUSSION FACTSHEET

Athletes who experience one or more of the signs and symptoms listed below after a bump, blow, or jolt to the head or body may have a concussion.

WHAT TO LOOK OUT FOR:

SYMPTOMS

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

SIGNS

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

RED FLAGS- SEEK URGENT MEDICAL EVALUATION:

1. Neck pain or tenderness
2. Double vision
3. Weakness/tingling/burning in arms or legs
4. Severe or increasing headache
5. Seizure or convulsions
6. Deteriorating conscious state
7. Vomiting
8. Increasingly restless, agitated or combative

TAKE THE FOLLOWING STEPS IF THE ATHLETE PRESENTS WITH NO RED FLAGS:

HEADS UP ACTION PLAN:

1. Remove the athlete from play.
2. Keep the athlete out of play the day of the injury.
3. Allow athlete to get a full night of uninterrupted sleep.
4. Encourage athlete to eat a balance diet.
5. Decrease screen use and strenuous brain activity.
6. Schedule an evaluation with an appropriate health care provider for further evaluation, management and activity recommendations.

IMPORTANT PHONE NUMBERS:

ECU Campus Rec & Wellness HEAD Athletic Trainer

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TO LEARN MORE, GO TO >> WWW.CDC.GOV/CONCUSSION

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the (NOCSA)National Operating Committee on Standards for Athletic Equipment.

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Appendix D – ECU CRW Post Concussion Treatment Plan

ECU CRW Post Concussion Treatment Plan

You have been flagged as someone who has suffered a hit to the head and need to be evaluated by the CRW Athletic Trainers. Please schedule your evaluation and read this document for further instructions.

What Now?

Participants suspected of having a Sport Related Concussion (SRC) or other Traumatic Brain Injury (TBI) will be referred for evaluation to a sports medicine professional with concussion evaluation experience. They will be suspended from IM Leagues, facility access and will not be allowed to start the return to play progression until they provide the ECU CRW Athletic Trainers (ATs) with documentation of clearance to start the return to play progression from a sports medicine physician. The injured participant needs to follow up with the AT regularly to monitor symptoms. If the participant does not follow treatment plan accordingly, they put their club at risk for a 1-year suspension. See Club Sports Handbook for more details.

Return to Play Progression

After sustaining a concussion, members will be required to go through the return to play (RTP) progression while supervised by an ECU CRW AT.

After a brief period of rest during the acute phase (24–48 hours), they can be encouraged to become gradually and progressively more active while staying below their cognitive and physical symptom-exacerbation thresholds (i.e., activity level should not bring on or worsen their symptoms) under the supervision of their AT. It is reasonable for participants to avoid vigorous exertion while they are recovering. There should be at least 24 hours (or longer) for each step of the progression. If any symptoms worsen during exercise, the participant should go back to the previous step. Closely monitored active rehabilitation programs involving controlled sub-symptom-threshold, submaximal exercise has been shown to be safe and may be of benefit in facilitating recovery. Resistance training should be added only in the later stages (stage 3 or 4 at the earliest). Refer to Figure 1 for more information.

Figure 1: Graduated Return to Sport/Play Strategy

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

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

Reinstatement

After the RTP has been completed, the AT deems the participant safe to return to activity, and the physician has not requested a follow up before their return, the AT will unsuspend the participant from IM Leagues and the membership portal. This will allow them to participate in intramural sports and regain access to the facilities. Only the ATs can give them this access again when the suspensions are due to injuries.

Contact the CRW Athletic Trainers at crwathletictraining@ecu.edu with comments, questions or concerns

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