


GENERAL INFORMATION

Player Name: _____ **DOB:** _____ **Sex:** M F Unspecified
Club Name: _____ **Division:** _____ **Level:** A AA AAA
Height: _____ **Weight:** _____ **Position:** Forward Defense Goalie

INJURY DESCRIPTION

Date of injury: _____ **Time:** _____ **Date you were aware of suspected injury:** _____
Arena location: _____ **Opposing team:** _____

A) Initial injury scenario	B) Resulted in contact with	C) Was contact anticipated?
<input type="checkbox"/> Contact with Opponent	<input type="checkbox"/> Boards	<input type="checkbox"/> Yes
<input type="checkbox"/> Contact with Opponent (From Behind)	<input type="checkbox"/> Ice	<input type="checkbox"/> No
<input type="checkbox"/> Contact with Teammate	<input type="checkbox"/> Opponent's Body	<input type="checkbox"/> Unsure
<input type="checkbox"/> Fall	<input type="checkbox"/> Stick	D) Was there a penalty called on play?
<input type="checkbox"/> Other	<input type="checkbox"/> Puck	<input type="checkbox"/> Yes
	<input type="checkbox"/> Net	<input type="checkbox"/> No
	<input type="checkbox"/> Other	<input type="checkbox"/> Unsure

E) Game Scenario	F) Period	G) Puck Possession	H) Score	I) Injury Location
<input type="checkbox"/> On ice practice	<input type="checkbox"/> 1 st period	<input type="checkbox"/> Yes	<input type="checkbox"/> Winning	<p>Mark an "X" of event on rink</p> 
<input type="checkbox"/> Regular game	<input type="checkbox"/> 2 nd period	<input type="checkbox"/> No	<input type="checkbox"/> Losing	
<input type="checkbox"/> Exhibition	<input type="checkbox"/> 3 rd period	<input type="checkbox"/> Just released	<input type="checkbox"/> Winning >2	
<input type="checkbox"/> Tournament	<input type="checkbox"/> Overtime	<input type="checkbox"/> Other	<input type="checkbox"/> Losing >2	
<input type="checkbox"/> Playoffs	<input type="checkbox"/> Other		<input type="checkbox"/> Tie Game	
<input type="checkbox"/> Other _____				
Additional Comments:				

REPORTED SYMPTOMS (CHECK ALL THAT APPLY)

<input type="checkbox"/> Visual problems	<input type="checkbox"/> Balance problems	<input type="checkbox"/> Drowsiness	<input type="checkbox"/> Irritability
<input type="checkbox"/> Nausea	<input type="checkbox"/> Feeling mentally foggy	<input type="checkbox"/> Sleeping more/less than usual	<input type="checkbox"/> Sadness
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Feeling slowed down	<input type="checkbox"/> Trouble falling asleep	<input type="checkbox"/> Nervous/anxious
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Sensitive to light	<input type="checkbox"/> More emotional
<input type="checkbox"/> Headache	<input type="checkbox"/> Difficulty remembering	<input type="checkbox"/> Sensitive to noise	<input type="checkbox"/> Fatigue

RED FLAG SYMPTOMS (CHECK ALL THAT APPLY): CALL 911 IMMEDIATELY WITH A SUDDEN ONSET OF ANY OF THESE SYMPTOMS

<input type="checkbox"/> Severe or increasing headache	<input type="checkbox"/> Neck pain or tenderness	<input type="checkbox"/> Seizure or convulsion
<input type="checkbox"/> Double vision	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Repeated vomiting
<input type="checkbox"/> Weakness or tingling/burning in arms/legs	<input type="checkbox"/> Deteriorating conscious state	<input type="checkbox"/> Increasingly restless, agitated or combative

Are there any other symptoms or evidence of injury to anywhere else? Yes No
 If yes, what: _____

Has this player had a concussion before? Yes No Prefer not to answer
 If yes, how many: 1 2 3 4 >5 Unsure

Any pre-existing medical conditions or take any medications? Yes No Prefer not to answer
 If yes, please list: _____

I [name of trainer completing this form] _____ recommended to player's parent/guardian that the player seek medical assessment as soon as possible. A medical assessment must be from a family doctor, pediatrician, emergency room doctor, sports-medicine physician, physiatrist, neurologist or a nurse practitioner.

Signature: _____ Phone Number: _____
 Email Address: _____

PLEASE NOTE: This form is to be completed by the team trainer in the event of a suspected concussion in any GKHA activity. Once this form is complete, give one copy of this report to parent/guardian and the other to head trainer. **EMAIL:** Riskmanagement@greaterkingstonhockey.com **Parents are to take this form for medical assessment appointment**