



GTHL Suspected Concussion Report Form

Player Name: _____ Player DOB: _____
 Date & Time of Injury: _____ Club Name: _____
 Division: _____ Level: _____ Game/Practice Location: _____

Injury Description:

Reported Symptoms (Check all that apply):

<input type="checkbox"/> Headache	<input type="checkbox"/> Feeling mentally foggy	<input type="checkbox"/> Sensitive to light
<input type="checkbox"/> Nausea	<input type="checkbox"/> Feeling slowed down	<input type="checkbox"/> Sensitive to noise
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Irritability
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Difficulty remembering	<input type="checkbox"/> Sadness
<input type="checkbox"/> Visual problems	<input type="checkbox"/> Drowsiness	<input type="checkbox"/> Nervous/anxious
<input type="checkbox"/> Balance problems	<input type="checkbox"/> Sleeping more/less than usual	<input type="checkbox"/> More emotional
<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Trouble falling asleep	<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"/> Headaches that worsen	<input type="checkbox"/> Can't recognize people or places	Was 911 called? Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Seizures or convulsions	<input type="checkbox"/> Increasing confusion or irritability	
<input type="checkbox"/> Repeated vomiting	<input type="checkbox"/> Weakness or numbness in arms/legs	
<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Persistent or increasing neck pain	
<input type="checkbox"/> Looks very drowsy/can't be awakened	<input type="checkbox"/> Unusual behavioural change	
<input type="checkbox"/> Slurred speech	<input type="checkbox"/> Focal neurologic signs (e.g. paralysis, weakness, etc.)	

Are there any other observable/reported symptoms: Yes No
 If yes, what: _____

Is there evidence of injury to anywhere else on body besides head? Yes No
 If yes, where: _____

Has this player had a concussion before? Yes No Prefer not to answer
 If yes, how many: _____

Does this player have any pre-existing medical conditions? Yes No Prefer not to answer
 If yes, please list: _____
Does this player take any medication? Yes No Prefer not to answer
 If yes, please list: _____

I [name of trainer completing this form]: _____ recommended to the player's parent or guardian that the player sees a medical professional immediately. A medical professional includes a family doctor, pediatrician, emergency room doctor, sports-medicine physician, neurologist or nurse practitioner.

Signature _____ Date: _____ Team Official Role: _____
 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 GTHL activity. Once this form is complete, give one copy of this report to parent/guardian and the other to GTHL head offices, **EMAIL: MFATA@GTHLCANADA.COM** or **FAX: 416-636-2035**. Parents are to take this form to a medical professional immediately. *Please review GTHL Concussion Policy for list of appropriate medical professionals for diagnosis.