GTHL Suspected Concussion Report Form

Player Name: _____ Player DOB: _____
Date & Time of Injury: _____ Club Name: _____
Division: _____ Level: _____ Game/Practice Location: _____
Position during Injury (please circle): Defense Forward Goalie

Injury Description: ☐Collison with boards ☐Collision with open ice ☐Collision with opponent ☐Fight ☐Collision with net ☐Checked from behind ☐Hit by puck ☐Hit by stick ☐Fall on ice ☐Other

Reported Symptoms (*Check all that apply):*

☐ Headache	☐ Feeling mentally foggy	☐ Sensitive to light
☐ Nausea	☐ Feeling slowed down	☐ Sensitive to noise
☐ Dizziness	☐ Difficulty concentrating	☐ Irritability
☐ Vomiting	☐ Difficulty remembering	☐ Sadness
☐ Visual problems	☐ Drowsiness	☐ Nervous/anxious
☐ Balance problems	☐ Sleeping more/less than usual	☐ More emotional
☐ Numbness/Tingling	☐ Trouble falling asleep	☐ Fatigue

Red Flag Symptoms (*Check all that apply): Call 911 immediately with a sudden onset of any of these symptoms*

☐ Headaches that worsen	☐ Can't recognize people or places	**Was 911 called?** Yes ☐ No ☐
☐ Seizures or convulsions	☐ Increasing confusion or irritability	
☐Repeated vomiting	☐ Weakness or numbness in arms/legs	
☐ Loss of consciousness	☐ Persistent or increasing neck pain	
☐ Looks very drowsy/can't be awakened	☐ Unusual behavioural change	
☐Slurred speech	☐ Focal neurologic signs (e.g. paralysis, weakness, etc.)	

Are there any <u>other</u> 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 <u>suspected</u> concussion in <u>any GTHL activity</u>. Once this form is complete, give one copy of this report to parent/guardian and the other to GTHL head offices,* ***EMAIL:*** ***<u>MFATA@GTHLCANADA.COM</u>*** *or* ***FAX: <u>416-636-2035</u>. Parents are to take this form to a medical professional immediately.***
****Please review GTHL Concussion Policy for list of appropriate medical professionals for diagnosis.***