North York Knights Hockey Association 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*
Was 911 called? Yes ☐ No ☐
☐ Headaches that worsen ☐ Can't recognize people or places ☐ 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.)

I, ____[*name of Head Coach (House League) or Team Trainer (Select/CDS) completing this form*] recommend to the player's parent or guardian that the player seeks medical assessment immediately. *A medical professional includes a family doctor, pediatrician, emergency room doctor, sports-medicine physician, neurologist, or nurse practitioner.*

Signature: ___________________________________ Date: _____________________________________

Phone Number: ___________________________ Email Address: __________________________________

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 or take any medication?
Yes ☐ No ☐ Prefer not to answer ☐
If yes, please list: ____