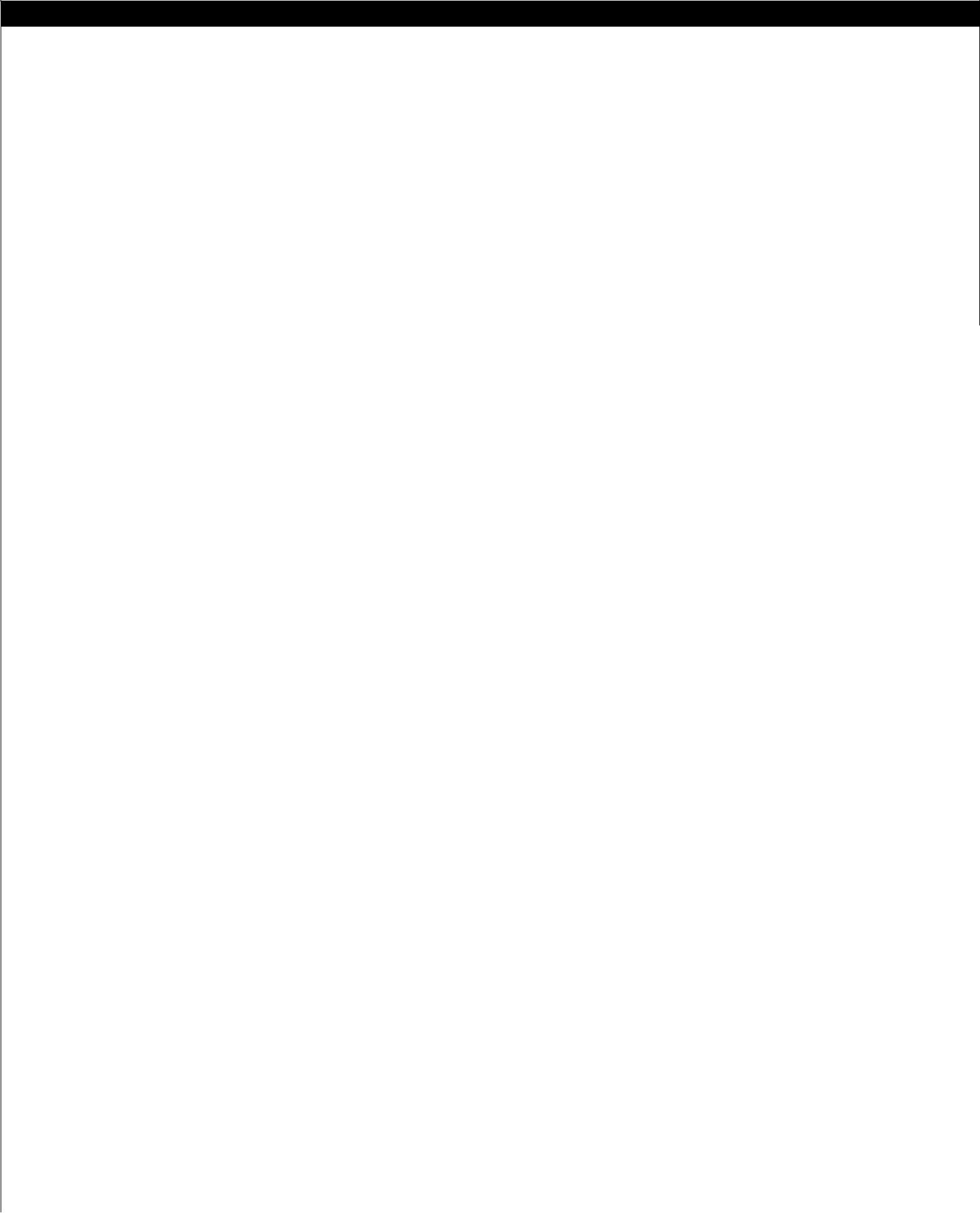
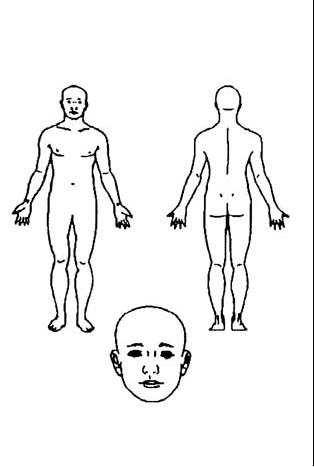
**Cochrane Ringette Association Sports Injury Report Form**



Injury details: *This report reflects an accurate record of the injured person’s reported symptoms of injury*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of person injured: | | | | | | | | |  |  |  |  |  | DOB: |  |  |  | / | / |  |
|  |  |  |  |  | (Day/Month/Year) | | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Date when injury occurred: | | | | | | | | | / | | / |  |  | Team & Division: | | | |  |  |  |
|  |  |  |  | |  |  | |  | |  | |  |  |  |  |  |  |  |  |  |
| Person injured: Athlete Coach Other: | | | | | | | | | | | |  |  | Gender: | M | | F |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Supervising coach: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |  | Witness: |  |  |  |  |  |  |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  | (Signature) | | | |  |  |  |  |  | (Signature) |  |  |  |
| First aid provided by: | | | | | | | | |  |  |  | Time of | |  |  |  | Initial treatment: | |  |  |
|  |  |  |  | : |  |  |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | first aid: | | |  | No treatment required | | |  |
|  |  |  |
|  |  |  |  |  |  |  | (Signature) | | | |  |  |  |  |  |  | CPR | RICER | |  |
| Nature of injury: | | | | | | |  | New injury | | | | Aggravated injury | | | |  |  |
|  | Recurrent injury | | | | Other: | | |  |  | Crutches | Sling/splint | |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | |  |  | |  | |  |  |  |  |  |  |  |  |  | |  |
| Did the injury occur during… | | | | | | | | | | |  |  |  |  |  |  | Dressing | Strapping | |  |
| Training | | | | | | |  |  |  |  | Game: | Other: | | |  |  | Massage | Stretching | |  |
| Symptoms of injury: | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Blisters | | | | | | |  |  |  |  | Inflammation/swelling | | |  | Spinal injury | | |  |  |  |
| Bleeding nose | | | | | | |  |  |  |  | Cramp |  |  |  | Cardiac problem | | |  |  |  |
| Bruising/contusion | | | | | | | | |  |  | Suspected bone fracture/break | | | | Electrical shock | | |  |  |  |
| Cut | | | |  |  |  |  |  |  |  | Dislocation |  |  |  | Burn | |  |  |  |  |
| Graze/abrasion | | | | | | |  |  |  |  | Concussion/head injury | | |  | Insect bite/sting | | |  |  |  |
| Sprain | | | |  |  |  |  |  |  |  | Loss of consciousness | | |  | Poisoning | | |  |  |  |
| Strain | | | |  |  |  |  |  |  |  | Respiratory problem | | |  | Other: | | |  |  |  |
|  |  |  |  | |  |  |  |  |  |  |  | | |  |  |  |  |  |  |  |
| Body part injured: | | | | | | |  |  |  |  | How did the injury occur? | | |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  | Collision with a fixed object | | | | Overbalance | | |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  | | | |  |  |  |  |  |  |
|  | right |  |  | left |  |  | left |  | right |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  | Collision/contact with another | | | | Overstretch | | |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  | person |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  | | | |  | | |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  | Fall from height/awkward landing | | | | Slip/trip | | |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  | | | |  | | |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  | Fall/stumble on same level | | | | Other: | | |  |  |  |



Extra detail regarding how the injury occurred:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Was protective equipment worn on the injured body part? | | | Yes No | |  |
|  |  |  |  |  |  |  |
| Follow up action: | None | Medical practitioner/physiotherapist | | Hospital |  |  |
|  |  |  |  |  |  |
|  | Ambulance | Other: | |  |  |  |
|  | |  |  |  |  |  |
| Signature of person completing form: | |  | Date: | / | / |  |
|  |  |  |  |  |  |  |

**Note**: Coaches without medical training should refer all medical decisions to appropriately qualified persons. Do notattempt to ‘diagnose’ an injury. Users of this form are advised that medical information should be treated confidentially.

**\*\*If suspected concussion please refer to concussion return to play guidelines\*\***