Sport Injury Report Form

This form is to be completed by a club official at the time of the injury and submitted to Provincial Sport Organization at the end of the game.

Submit completed form to:
ringette@sportnovascotia.ca
within 2 DAYS of injury occurrence

SECTION A: PERSON INJURED

☐ Player ☐ Official ☐ Coach ☐ Other

First Name | Last Name | Date of Injury

Address | City | Prov. | PC | Phone #

Email Address:

(1st) Witness Name: | Contact Number:

(2nd) Witness Name: | Contact Number:

LOCATION OF INJURY: ☐ Outdoor Rink ☐ Indoor Rink ☐ Bleachers ☐ Locker Room ☐ Outside of Venue

Name of Arena | Name of Team/Organization: | City:

Form Completed By: | Contact #:

AGE CATEGORY: ☐ U9 ☐ U10 ☐ U12 ☐ U14 ☐ U16 ☐ U19 ☐ 18+ ☐ 30+

LEVEL: ☐ AA ☐ A ☐ B ☐ C ☐ Rec. ☐ House Leag. **PERIOD OF PLAY:** ☐ First ☐ Second

INJURY OCCURED DURING: ☐ Pre Season ☐ Post Season ☐ Regular Season ☐ Playoffs

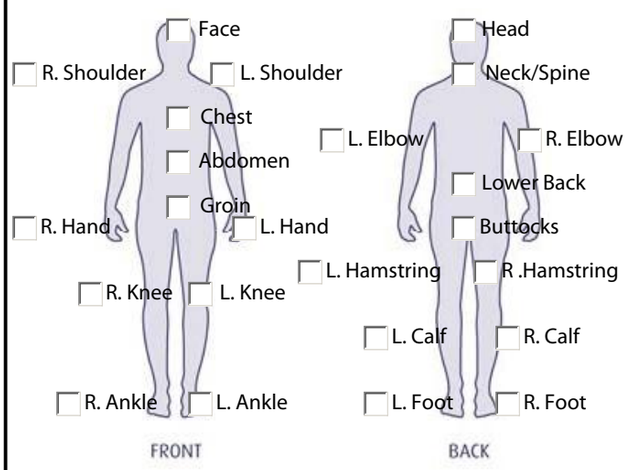
TIME OF INJURY ☐ AM ☐ PM

TYPE OF ACTIVITY: ☐ Tryout ☐ Game ☐ Recreation ☐ Practice

PLEASE COMPLETE SECTION 'A' ABOVE IN FULL AND AS MUCH OF SECTION 'B' BELOW AS POSSIBLE

SECTION B: DETAILS OF INJURY

Body Part(s) Injured (Please Select all that apply)



Weight | Height (Inch)

Please indicate in the box below what caused the injury & whether it could have been avoided, i.e. equipment failure (include make/model).

Please indicate on the picture below where on the ice the incident occurred.
Describe in words if using on-line form.

SUBJECT INVOLVED: ☐ Male ☐ Female Year of Birth

INJURY TYPE: ☐ Contact ☐ Non-contact

NATURE OF INJURY:
☐ Dislocation ☐ Skin Injury
☐ Sprain / Strain ☐ Swelling ☐ Fracture
☐ Head Injury ☐ Contusions ☐ Other, please specify

CONCUSSION: Presence of any of the following signs & symptoms MAY suggest a concussion.

☐ Loss of Consciousness	☐ Don't feel right	☐ Confusion
☐ Seizure or convulsion	☐ Feeling slowed down	☐ Sadness
☐ Pressure in head	☐ Feeling like in a fog	☐ Amnesia
☐ Nausea or Vomiting	☐ Difficulty concentrating	☐ Headache
☐ Blurred Vision	☐ Difficulty remembering	☐ Neck Pain
☐ Balance Problems	☐ Fatigue or low energy	☐ Dizziness
☐ Sensitivity to light	☐ More emotional	☐ Drowsiness
☐ Sensitivity to noise	☐ Nervous or anxious	☐ Irritability

CARE: ☐ Trainer ☐ Hospital Care ☐ EMS ☐ Family Physician

IF TREATED AT HOSPITAL, PARTY TRANSPORTED BY:
☐ Ambulance ☐ Personal/Private Vehicle

INITIAL TREATMENT:
☐ RICE (Rest, Immobilize, Cold, Elevate)
☐ CPR ☐ SCAT 2 ☐ Manual Therapy
☐ Dressing ☐ Sling/Splint ☐ Wrapping/Taping
☐ Stretch/Exercises ☐ None Given - referred elsewhere

WAS INJURED PART WEARING PROTECTIVE EQUIPMENT?
☐ Yes ☐ No If not, why?

HAS INJURED PARTY FILED AN INSURANCE CLAIM? ☐ Yes ☐ No

ANTICIPATED INJURY TIME LOSS:
☐ 0 Days ☐ 1-5 Days ☐ 5-10 Days ☐ 10+ Days

Signature: | **Date of Injury:** | **Current Date:**

Please type your name when using on-line form

ALL INFORMATION COLLECTED ON THIS FORM OF A PERSONAL NATURE IS STRICTLY CONFIDENTAL AND WILL NOT BE DISCLOSED TO A THIRD PARTY.