



AMHA INJURY REPORT

To be completed for any injury where player leaves the ice surface and doesn't complete the icetime or is assessed further medical attention by Team Safety Coach

DATE OF INJURY: Mo. ___ / Day ___ / Yr. ___

INJURED PARTICIPANT: Player Team Official Game Official Spectator

Name: _____ Gender: M F Birthdate: Mo. ___ / Day ___ / Yr. ___

Address: _____

City / Town: _____ Province: _____ Postal Code: _____ Phone: (___) _____

Parent / Guardian: _____ Email Address: _____

AGE DIVISION

Under-7 Under-9 Under-11 Under-13
 Under-15 Under-18 Under-21

CATEGORY

AAA Tier 1 Tier 3 Tier 5 House
 AA Tier 2 Tier 4 Other Major Junior

BODY PART INJURED

Arm:		Leg:		Head:	Trunk:	Back:
Left	Right	Left	Right			
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Shin	<input type="checkbox"/> Shin	<input type="checkbox"/> Eye Area	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Neck
<input type="checkbox"/> Upper arm	<input type="checkbox"/> Upper arm	<input type="checkbox"/> Knee	<input type="checkbox"/> Knee	<input type="checkbox"/> Face	<input type="checkbox"/> Chest	<input type="checkbox"/> Lower
<input type="checkbox"/> Collarbone	<input type="checkbox"/> Collarbone	<input type="checkbox"/> Toe	<input type="checkbox"/> Toe	<input type="checkbox"/> Throat	<input type="checkbox"/> Ribs	<input type="checkbox"/> Upper
<input type="checkbox"/> Elbow	<input type="checkbox"/> Elbow	<input type="checkbox"/> Thigh	<input type="checkbox"/> Thigh	<input type="checkbox"/> Skull	Pelvis:	
<input type="checkbox"/> Hand/Finger	<input type="checkbox"/> Hand/Finger	<input type="checkbox"/> Foot	<input type="checkbox"/> Foot	<input type="checkbox"/> Dental	<input type="checkbox"/> Hip	<input type="checkbox"/> Groin
<input type="checkbox"/> Forearm/Wrist	<input type="checkbox"/> Forearm/Wrist	Other: _____				

NATURE OF CONDITION (not a diagnosis)

Concussion Laceration Fracture
 Sprain Strain Contusion
 Dislocation Separation Internal Organ Injury

ON-SITE CARE

On-Site Care Only Refused Care

Sent to Hospital by: Ambulance Car

CAUSE OF INJURY

Hit by Puck
 Collision with Boards
 Non-Contact Injury
 Hit by Stick
 Collision on Open Ice
 Collision with Opponent
 Fall on Ice
 Checked from Behind
 Collision with Net
 Fight
 Blindsiding

Was the injured player in the correct league and level for their age group?
 Yes No

Was this a sanctioned Hockey Canada activity?
 Yes No

ADDITIONAL INFORMATION

Has the player sustained this injury before?
 Yes No

If "Yes" how long ago? _____

Was a penalty called as a result of the incident?
 Yes No

Estimated absence from hockey?
 1 week 1-3 weeks 3+ weeks

DESCRIBE HOW INCIDENT HAPPENED

(Attached additional page if necessary)

TEAM INFORMATION

(To be completed by a Team Official) Association: _____

Team Name: _____

Team Official (Print): _____

Team Official Position: _____

Signature: _____

Date: _____

I hereby authorize any Health Care Facility, Physician, Dentist or other person who has attended or examined me/my child, to furnish Hockey Canada any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all dental, hospital, and medical records. A photo static/electronic copy of this authorization shall be considered as effective and valid as the original.

Signed _____

Date: _____