Head Injury Incident Report

Submit via e mail to deb@bclacrosse.com or fax to 604-421-9775 ***within 7 days*** *of the incident.*
Please provide a copy to your ***Team Manager*** *as well.*

DISCIPLINE: ☐ Box ☐ Men's Field ☐ Women's Field

ASSOCIATION/TEAM: _____DIVISION: _____

DATE & TIME OF INCIDENT: _____ LOCATION: (City/Facility) _____

Injured Player Name: _____ Player Date of Birth: Mth_____Day_____Year_____

Describe incident in detail (use additional pages if necessary and attach photos):

Was any penalty called on the play that caused the injury? ☐ Yes ☐ No

If Yes, what was the penalty?

_____

Did the player receive medical attention? ☐ Yes ☐ No

Did the player go to the hospital? ☐ Yes ☐ No

If so, describe diagnosis and treatment:

_____

_____

What is the make/model of the helmet worn? _____

What is the make/model of the facemask worn? _____

To the best of your knowledge, was the equipment installed correctly? ☐ Yes ☐ No

Name of individual completing this form: _____ Signature: _____

Role (coach, manager, parent, player, etc.) _____ Date: _____

Phone Number: _____ Email Address: _____

Witness to Incident: Role (coach, manager, parent, player, etc.) _____

Name: _____ Signature: _____ Date: _____

Phone Number: _____ Email Address: _____