



## Return to Play Policy - Concussions

To be followed when a player leaves the ice with concussion-like symptoms or is asked to return to the bench at the discretion of the Safety Coach/Trainer following an on-ice incident that may have resulted in possible concussion.

**CALL 911 if player is unconscious, has decreased consciousness, has a suspected neck or life threatening injury.**

OMHA has implemented the HeadCheck Health App at the Bantam and Midget levels for the 2019/2020 season.



1. Safety Coach/Trainer performs on-ice injury assessment (see Concussion Recognition tool)
2. If showing any positive signs or symptoms of concussion, according to the concussion recognition tool, player is safely removed from ice, removed from play, and returns to dressing room with assistance.
3. Safety Coach/Trainer completes the **Hockey Canada Injury Report** (attached). First page of report sent to OMHA Safety Director.
4. Safety Coach/Trainer should provide the player (or parent) with the following documents before the player leaves the rink, if possible:
  - Return to Play Form**
  - Sport Concussion Information Handout (attached)
5. Player sees physician and/other health care providers for treatment and concussion management.

### *IF CONCUSSION FREE*

IF, after visiting a Physician, **no concussion is suspected**, player may return to play once the following are completed:

- Player has returned the completed **Return to Play Form** to the Safety Coach/Trainer/Manager
- If player is in Bantam or Midget, they will need to submit the Safety Coach clearance form to HeadCheck Health (attached)
- Safety Coach/Trainer/Manager submits **Hockey Canada Injury Report** to OMHA Safety Director

### *SUSPECTED CONCUSSION or CONCUSSION DIAGNOSIS*

- Safety Coach/Trainer notifies OMHA Safety Team (*Bantam/Midget Division Safety Coaches update on HeadCheck*)
- Player follows treatment plan as directed by Concussion Specialist (Physician, Chiropractor, and/or Physiotherapist); obtaining signatures on **Return to Play Form** as rehabilitation takes place.

When player has received final Physician clearance to return to play without any restrictions, player may return to play once the following are completed:

- Return to Play Form** to OMHA Safety team.
- Return to Play Form** added to HeadCheck at Bantam/Midget Divisions.



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## Concussion Recognition Tool

OMHA has implemented new policy to utilize the Concussion Recognition Tool 5 at all divisions if mechanism of injury (impact, fall, collision) suspects concussion at practise, game or off-ice. See following page.

Please see the following page for a full printable copy.

2019-2020

# CONCUSSION RECOGNITION TOOL 5 ©

To help identify concussion in children, adolescents and adults



FIFA®



FEI

Supported by

## RECOGNISE & REMOVE

Head impacts can be associated with serious and potentially fatal brain injuries. The Concussion Recognition Tool 5 (CRT5) is to be used for the identification of suspected concussion. It is not designed to diagnose concussion.

### STEP 1: RED FLAGS – CALL AN AMBULANCE

If there is concern after an injury including whether ANY of the following signs are observed or complaints are reported then the player should be safely and immediately removed from play/game/activity. If no licensed healthcare professional is available, call an ambulance for urgent medical assessment.

- Neck pain or tenderness
- Double vision
- Weakness or tingling/ burning in arms or legs
- Severe or increasing headache
- Seizure or convulsion
- Loss of consciousness
- Deteriorating conscious state
- Vomiting
- Increasingly restless, agitated or combative

### Remember:

- In all cases, the basic principles of first aid (danger, response, airway, breathing, circulation) should be followed.
- Assessment for a spinal cord injury is critical.
- Do not attempt to move the player (other than required for airway support) unless trained to so do.
- Do not remove a helmet or any other equipment unless trained to do so safely.

If there are no Red Flags, identification of possible concussion should proceed to the following steps:

### STEP 2: OBSERVABLE SIGNS

Visual clues that suggest possible concussion include:

- Lying motionless on the playing surface
- Slow to get up after a direct or indirect hit to the head
- Disorientation or confusion, or an inability to respond appropriately to questions
- Balance, gait difficulties, motor incoordination, stumbling, slow laboured movements
- Blank or vacant look
- Facial injury after head trauma

### STEP 3: SYMPTOMS

- Headache
- Blurred vision
- "Pressure in head"
- Balance problems
- Nausea or vomiting
- Drowsiness
- Dizziness
- More emotional
- Sensitivity to light
- Sensitivity to noise
- Fatigue or low energy
- "Don't feel right"
- More irritable
- Sadness
- Nervous or anxious
- Neck Pain
- Difficulty concentrating
- More irritable
- Difficulty remembering
- Feeling slowed down
- Feeling like "in a fog"

### STEP 4: MEMORY ASSESSMENT

(IN ATHLETES OLDER THAN 12 YEARS)

- Failure to answer any of these questions (modified appropriately for each sport) correctly may suggest a concussion:
- "What venue are we at today?"
  - "Which half is it now?"
  - "Did your team win the last game?"
  - "What team did you play last week/game?"
  - "Did your team win the last game?"
  - "Who scored last in this game?"

### Athletes with suspected concussion should:

- Not be left alone initially (at least for the first 1-2 hours).
- Not drink alcohol.
- Not use recreational/ prescription drugs.
- Not be sent home by themselves. They need to be with a responsible adult.
- Not drive a motor vehicle until cleared to do so by a healthcare professional.

The CRT5 may be freely copied in its current form for distribution to individuals, teams, groups and organisations. Any revision and any reproduction in a digital form requires approval by the Concussion in Sport Group. It should not be altered in any way, rebranded or sold for commercial gain.

**ANY ATHLETE WITH A SUSPECTED CONCUSSION SHOULD BE IMMEDIATELY REMOVED FROM PRACTICE OR PLAY AND SHOULD NOT RETURN TO ACTIVITY UNTIL ASSESSED MEDICALLY, EVEN IF THE SYMPTOMS RESOLVE**



## Sport Related Concussion – Information Handout

### What is a Concussion?

A concussion is a brain injury. A concussion most often occurs without loss of consciousness. However, a concussion may involve loss of consciousness. Concussions are caused by the brain moving inside of the skull. The movement causes damage that changes how brain cells function, leading to symptoms that can be physical (headaches, dizziness), cognitive (problems remembering or concentrating), or emotional (feeling depressed).

The majority of people (80-90%) who experience concussion recover with no lingering symptoms.

### How Concussions Happen?

Any impact (direct or indirect) to the head, face or neck or a blow to the body which causes a sudden jolting of the head and results in the brain moving inside the skull may cause a concussion.

### Common Symptoms and Signs of a Concussion Symptoms:

#### *Important note to parents and players:*

Signs and symptoms may have a delayed onset (may be worse later that day, next morning, or even days later), so players should continue to be observed even after the initial symptoms and signs have returned to normal.

A player may show any one or more of these symptoms or signs.

#### Physical

Headache  
Nausea  
Vomiting  
Blurred or double vision  
Seeing stars  
Poor balance  
Dizziness  
Poor co-ordination

#### Cognitive

Feeling "slowed down"  
Difficulty concentrating  
Feeling dazed  
Memory problems  
Unable to multi-task  
Not yourself  
Sleep disturbance

#### Behavioural

Frustration  
Anger  
Feeling down/depressed  
Anxious  
Sleeping more than usual  
Difficulty falling asleep

### The first 24-48 hrs after Concussion - REST

#### What should you do if concussion is suspected?

- Recognize and remove the player from the current game or practice.
- Do not leave the player alone, monitor symptoms and signs.
- Do not administer medication.
- Inform the coach, parent or guardian about the injury.
- The player should be evaluated by a medical doctor as soon as possible, within 24-72 hrs.
- The player must not return to play in that game or practice, and must follow the 6-step return to play strategy and receive medical clearance by a physician.



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**If you develop any of the following symptoms, go to the nearest Emergency Department:**

- Stiff neck
- Fluid and/or blood leaking from nose or ears
- Difficulty waking up
- Difficulty remaining awake
- Fever
- Headache that gets worse, lasts a long time, or is not relieved by over-the-counter pain relievers
- Vomiting
- Problems walking and talking
- Problems thinking
- Seizures
- Changes in behaviour or unusual behaviour
- Double or Blurred vision
- Changes in speech (slurred, difficult to understand or does not make sense)

**How is a Concussion Treated? How long does it take to get better?**

Your physician and or other health care provider trained in concussion management will recommend a player should rest physically and mentally.

- Avoiding activities that increase any of the players symptoms, such as general physical exertion, sports, or any vigorous movements.
- This rest also includes limiting activities, which require thinking and mental concentration, such as playing video games, watching TV, school work, reading, texting, or using a computer, if these activities trigger players symptoms or worsen them.
- Symptoms and timelines may be very different from player to player, therefore ongoing concussion management and individualized rehabilitation plans are key in player Returning to Learn and Returning to Sport.
- Most recent research notes that most sport related concussions are resolved in less than two weeks in adults and less than 4 weeks in children.

**Return to Learn**

- Slowly returning to school is best. As a student, it can be hard for you to focus, remember and process information, which can affect how well a player learns and performs at school. Players and their school staff, including teachers and counselors, can work together to adjust players school work and school environment so a player can gradually return to full school activities and performance.
- A successful return to school must come before a return to play, but a return to physical activity may take place in parallel with a return to school.



## Return to Play Protocol

### STEP 1

Light activities of daily living which do not aggravate symptoms or make symptoms worse. When able to tolerate step 1 without symptoms and signs, proceed to step 2.

### STEP 2

Light aerobic exercise, such as walking or stationary cycling. Monitor for symptoms and signs. No resistance training or weight lifting. When able to tolerate step 2 without symptoms and signs, proceed to step 3.

### STEP 3

Sport specific activities and training (e.g. skating). When able to tolerate step 3 without symptoms and signs, proceed to step 4.

### STEP 4

Practice and drills without body contact. May add light resistance training and progress to heavier weights. The time needed to progress from non-contact to contact exercise will vary with the severity of the concussion and the player. When able to tolerate step 4 without symptoms and signs, proceed to step 5.

### STEP 5

Begin practice and drills with body contact. When able to tolerate step 5 without symptoms and signs, and medical clearance is provided, proceed to step 6.

### STEP 6

Return to Game play. (The earliest a concussed athlete should return to play is one week.)

***There should be at least 24 hrs (or longer) for each step of the progression. If any of the symptoms worsen during exercise, you should go back to the previous step.***



# Return to Play Form

This form is to be given to any player after any injury (game, practice, off-ice) in which a concussion is suspected.

Dear Physician:

Thank you for seeing our player. Your assessment is critical to the safe recovery of our player. OMHA has a Concussion Policy in place for any player suspected of having a concussion. As per our policy, a physician is required to provide clearance for any player that is suspected or diagnosed concussion criteria to either Return to Play or to proceed with more supervised concussion management.

- Please complete SECTION 1 below.
- Please complete SECTION 2 only if player has sustained concussion and is unable to return to play after 1 week

## SECTION 1

- After assessment, it is my impression that the player is medically able to return to play without restrictions.
- After assessment, it is my impression that the player is medically not able to return to play and requires further supervised management prior to returning to play. SECTION 2 should be completed as the athlete rehabilitates.

Supervised concussion management prior to Return to Play. SECTION 2 should be completed as player rehabilitates.

Name of Physician: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

## SECTION 2 – to be completed by a health care provider

<p>1. FOLLOW-UP &amp; Rehabilitation Plan</p> <p><input type="checkbox"/> Player has had follow-up assessment/testing with health care provided trained in concussion management. An individual rehabilitation plan has been recommended/implemented to support recovery.</p> <p>Date completed: _____</p>
<p>2. Rehabilitation Plan Completed</p> <p><input type="checkbox"/> Athlete completed all necessary clinical rehabilitation requirements and is discharged to Physician for further Return to Play recommendations (<i>refer to Concussion Return to Play Procedure</i>)</p> <p>Date completed: _____</p>
<p>3. FINAL PHYSICIAN CLEARANCE</p> <p><input type="checkbox"/> After final assessment, it is my impression that medically the player is able to return to play without any restrictions.</p> <p>Date Submitted to Safety Coach: _____</p>
<p>4. Form Submission to OMHA and HeadCheck (<i>Bantam/Midget Divisions</i>)</p>



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Player has returned completed Clearance Form to Safety Coach/Trainer.

Date Submitted to Safety Director: \_\_\_\_\_

F E N I N A L



# HOCKEY CANADA INJURY REPORT

PAGE 1/2



See reverse for mailing address

Forms must be filled out in full or form will be returned. This form must be completed for each case where an injury is sustained by a player, spectator or any other person at a sanctioned hockey activity

CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF THE INJURY DATE. DATE OF INJURY: \_\_\_/\_\_\_/\_\_\_  
Mo. Day Yr.

**INJURED PARTICIPANT:**  Player  Team Official  Game Official  Spectator

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Sex:  M  F  
Mo. Day Yr.

Address: \_\_\_\_\_

City / Town: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_

## DIVISION

- Initiation  Novice  Atom  Peewee  
 Bantam  Midget  Juvenile  Junior

## CATEGORY

- AAA  A  BB  CC  DD  House  Minor Junior  Adult Rec.  
 AA  B  C  D  E  Major Junior  Senior  Other \_\_\_\_\_

## BODY PART INJURED

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

## NATURE OF CONDITION

- 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

## INJURY CONDITIONS

Name of arena / location: \_\_\_\_\_

- Exhibition/Regular Season  Period #2  
 Playoffs/Tournament  Period #3  
 Practice  Overtime: \_\_\_\_\_  
 Try-outs  Dry Land Training  
 Other  Gradual Onset  
 Warm-up  Other Sport  
 Period #1  Other: \_\_\_\_\_

## 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

## LOCATION

- Defensive Zone  Offensive Zone  Neutral Zone  
 Behind the Net  3 ft. from Boards  Spectator Area  
 Parking Lot  Dressing Room  Bench  
 Other: \_\_\_\_\_

## WEARING WHEN INJURED

- Full Face Mask  
 Intra-Oral Mouth Guard  
 Half Face Shield/Visor  
 Throat Protector  
 Helmet/No Face Shield  
 No Helmet/No Face Shield  
 Short Gloves  
 Long Gloves

## 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 ACCIDENT HAPPENED

(Attach page if necessary)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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: \_\_\_\_\_  
(Parent/Guardian if under 18 years of age)  
Date: \_\_\_\_\_

## TEAM INFORMATION

(To be completed by a Team Official)

Association: \_\_\_\_\_

Team Name: \_\_\_\_\_

Team Official (Print): \_\_\_\_\_

Team Official Position: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## HEALTH INSURANCE INFORMATION

**THIS MUST BE FILLED OUT IN FULL OR FORM PROCESSING WILL BE DELAYED**

Occupation:  Employed Full-time  Employed Part-time  
 Unemployed  Full-Time Student

Employer (If minor, list parent's employer): \_\_\_\_\_

1. Do you have provincial health coverage?  Yes  No Province: \_\_\_\_\_

2. Do you have other insurance?  Yes  No  
(IF "YES", PLEASE SUBMIT CLAIM TO YOUR PRIMARY HEALTH INSURER.)

3. Has a claim been submitted?  Yes  No  
(IF "YES", PLEASE FORWARD PRIMARY INSURER EXPLANATIONS OF BENEFITS.)

Make Claim Payable To:  Injured Person  Parent  Team  Other: \_\_\_\_\_

Branch APPROVAL



# HOCKEY CANADA INJURY REPORT

PAGE 2/2



## PHYSICIAN'S STATEMENT

Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_

Name of Hospital / Clinic: \_\_\_\_\_ Address: \_\_\_\_\_

Nature of Injury: \_\_\_\_\_ Date of First Attendance: \_\_\_\_\_

\_\_\_\_\_ Claimant will be totally disabled:

\_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

\_\_\_\_\_ Is the injury permanent and irrecoverable?  No  Yes

Give the details of injury (degree): \_\_\_\_\_

Prognosis for recovery: \_\_\_\_\_

Did any disease or previous injury contribute to the current injury?  No  Yes (describe): \_\_\_\_\_

Was the claimant hospitalized?  No  Yes (give hospital name, address and date admitted): \_\_\_\_\_

Names and addresses of other physicians or surgeons, if any, who attended claimant: \_\_\_\_\_

I certify that the above information is correct and to the best of my knowledge,

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## DENTIST STATEMENT

Limits of coverage: \$1,250 per tooth, \$2,500 per accident  
Treatment must be completed within 52 weeks of accident

UNIQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO.

**Patient**

\_\_\_\_\_

Last name \_\_\_\_\_ Given name \_\_\_\_\_

\_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City / Town \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

**Dentist**

\_\_\_\_\_

\_\_\_\_\_

PHONE NO \_\_\_\_\_

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM DIRECTLY TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM / HER

\_\_\_\_\_

SIGNATURE OF SUBSCRIBER

FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION.

\_\_\_\_\_

DUPLICATE FORM

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT.

I ACKNOWLEDGE THAT THE TOTAL FEE OF \$\_\_\_\_\_ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR THE SERVICES RENDERED.

I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

\_\_\_\_\_

SIGNATURE OF (PATIENT/GUARDIAN) \_\_\_\_\_ OFFICE VERIFICATION \_\_\_\_\_

DATE OF SERVICE DAY / MO. / YR.	PROCEDURE	INITIAL TOOTH CODE	TOOTH SURFACE	DENTIST'S FEE	LAB CHARGE	TOTAL CHARGE

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE & OE. TOTAL FEE SUBMITTED

NOTE: All benefits subject to insurer payor status, provisions of the policy, Hockey Canada sanctioned events.