TEAM SAFETY AND FIRST AID RESPONSE PLAN

Ringette is a very fast and physically demanding sport. Even with the best training and preparation, accidents and injuries can occur. Thankfully many of the injuries are minor and do not require a player to miss a shift or game. However there is the rare occasion when injuries can be more severe.

Team coaches and staff have taken steps to establish a basic safety and first aid guideline for all injuries on and off the ice.

Teams should dedicate an individual to act as the teams "Safety/First Aid Coordinator" to facilitate the teams medical and safety plan and response. Teams will have a first aid kit on the bench, note the presence and location of the rink AED (Automated External Defibrillator) and research the nearest hospital locations for team games, activities and events - especially when outside of Spruce Grove.

The following are procedures will be used if a player is injured during a game:

- The first lines of response if a player is down on the ice will be to have the designated coach (or alternate) assess the player on the ice;
- If the condition of the player is considered more than a minor injury, the safety/first aid coordinator may be called to the ice by the coach for further assessment;
- If the injury is deemed to be more serious than what can be handled by the coaches/first aid coordinator, than an ambulance will be called;
- At that time, all players will be instructed to leave the ice and the game stopped;
- We ask that parents ***do not*** come onto the ice/proceed to the dressing room when an injury initially occurs. The above steps need to be followed for the safety of all those involved;
- If the situation is deemed more than a minor injury, the parent of the injured player will be signaled to come down to the ice or dressing room as soon as possible by the coaches attending to the player.

Concussions of any degree are a serious concern and all injuries to the head will be treated according to the strict guidelines established by Hockey and Ringette Alberta. Please review the attached concussion guidelines and share this information with your daughter. Your athlete should be encouraged to report any concussion type symptoms to the coaches, especially if they have come off the ice unassisted.

As always, we hope we never have to use the above protocol, but felt it is best to be prepared. Please keep the coaches/team manager aware of any medical change to your daughter throughout the year that could impact her care/medical needs.

We look forward to a safe and successful season!!

TEAM MEDICAL RESPONSE PLAN

OBJECTIVES OF THE MEDICAL RESPONSE PLAN

1. To facilitate and coordinate an effective response for injuries and medical incidents;
2. To lessen the impact and potential loss to the injured player.

GOALS OF THE MEDICAL RESPONSE PLAN

1. To ensure timely, competent response to medical situations;
2. To provide an effective means of contacting emergency personnel;
3. To provide immediate treatment to the ill or injured;
4. To provide transport of the ill or injured to a medical facility;
5. To safeguard the public; and
6. To prevent injuries to rescuers.

POTENTIAL INCIDENTS

The purpose of this section is to identify potential injuries and incidents based on the tasks being performed throughout the season which would include all on and off ice activities and events:

Potential injury or medical incidents may include the following, but of course are not limited to:

- Concussion;
- Strains and Sprains;
- Lacerations;
- Broken Limbs;
- Breathing/Respiratory Problems;
- Heart and Stroke.

INJURY/MEDICAL INCIDENT RESPONSE

If there is an injury or medical incident:

- Provide first aid (if safe to do so and if you are trained) and immediately contact EMS.
- The team first aid and safety designate will contact the off-site emergency medical services (EMS) if signaled from the coaching staff.
- The signal from the coaches to theteam first aid and safety designate if EMS is to be activated is the hand signal similar to a referee wanting to restart the shot clock. The signal is hand overhead and moving the index finger in a circular motion.

- Call **9-1-1.**
- If possible assist coaching staff to provide first aid until the EMS arrives at the scene. Once the EMS arrives, brief them on the casualty's condition and officially hand over the care of the casualty to EMS.
- If you suspect serious injuries don't move the casualty.
- Provide assistance – ask the casualty how you can help him/her.
- Keep the casualty warm.

EMERGENCY EQUIPMENT

First aid kits are issued to all teams by SGRA. Kits are to be held either by coaching staff on the bench or the first aid and safety designate if applicable. AED's should be identified by coaching staff or first aid and safety designate in facilities where team events and activities are taking place.

EMERGENCY COMMUNICATION(S)

- Perform on-site phone checks – confirm that your cell phone works!
- Please note that some facilities may have limited cell phone reception. Ensure that an alternate source of communications is located prior to commencement of team activities.

TRANSPORTING ILL OR INJURED PERSONS

- Minor injuries or illnesses will be assessed and treated by a designated first aider. Serious Injury and Illness will be assessed and treated by a designated first aider until appropriate medical support arrives.
- Based on the first aider findings, the following options are available:
    - Have a coach, or designate, along with the first aid and safety designate drive the casualty to a medical facility.
    - In the event of a serious injury/illness, individuals should only be transported by using ambulance services and EMS personnel.
    - If the first aid and safety designate needs to leave the facility, ensure an alternate first aider is identified.

TEAM ACTIVITY AND EVENT
FIRST AID ACTION PLAN

Arena/Facility Name:	
Address:	
Phone #:	

EMERGENCY TELEPHONE NUMBERS:			
Emergency:		Hospital:	
Ambulance:		Police:	
Fire Department:		Other:	

Please locate and identify the following areas:

- ❒ First Aid Room and/or Kits
- ❒ Certified First Aid Responders on site
- ❒ Nearest AED
- ❒ Routes for Ambulance Crews
- ❒ Cell Phone Reception
- ❒ Nearest Telephones
- ❒ Emergency Exits

RESPONSIBILITITES:

TEAM SAFETY AND FIRST AID COORDINATOR

- Most qualified person available with training in first aid and emergency response;
- Familiarize yourself with arena/facility emergency equipment;
- In event of injury, assess player
- Take control of an emergency situation until medical personnel arrive;
- Appoint Call and Control individuals to assist with emergency incidents.

CALL PERSON

- Location of telephones to use for emergency purposes;
- List of emergency telephone numbers;
- Directions to arena/facility;
- Best route in and out for ambulance crew;
- Communicate with Team Safety/First Aid Coordinator and Control Person.

CONTROL PERSON

- Ensure proper room for Team Safety/First Aid Coordinator and ambulance crew;
- Discuss emergency action plan with arena staff, officials and opponents;
- Ensure that the route for the ambulance crew is clear and available.
- Seek highly trained medical personnel (Ex: MD, Nurse) to assist injured player if requested by Charge Person.
- Discuss player's injury and status with parents.

ATHLETE RETURN TO PLAY

SGRA Return to Play Form (RTP) must be used when an athlete returns from injury/concussion. The form must be completed by a health care provider for any athlete that has been removed from play due to injury and had to seek medical attention. The RTP must be signed by the athlete's parent/guardian consenting to the health care provider's recommendations. A copy of this form will be retained by the coach/manager with a notification to the applicable director. This will help to ensure our athletes are not put into game situations before they have fully recovered from an injury.

PLAYER NAME: _____

DATE OF INJURY: _____

PRIMARY COMPLAINT: _____

DIAGNOSIS: _____

The following are considerations/restrictions with respect for athlete to return to play:

Name of Treating Healthcare Professional	Signature	Date

I agree with the above plan and am knowledgeable about my child's condition and situation:

Name of Parent/Guardian	Signature	Date

ALL SPORT
INSURANCE MARKETING LTD.
417 - 1367 West Broadway
Vancouver, BC V6H 4A9
Phone 604-737-3018
Fax 604-737-3076
Toll 1-877-992-2288

ATHLETIC ACCIDENT CLAIM FORM

SECTION I (please print)

Last Name of Claimant | First Name | Birth Date

Mailing Address

City | Province | Postal Code

If a Minor, Name of Parent

Home Phone ( ) | Business Phone ( )

SECTION II

Date of Accident | Hour a.m./p.m.

Location of Accident

What is the Injury?

Date of First Treatment

Name of Hospital taken to

Date of Admittance | Hour a.m./p.m.

Date of Discharge | Attending Physician or Dentist

SECTION III Describe fully how the accident happened.

SECTION IV (your sports accident policy is an excess accident benefits policy; proof of exhausting all other insurance must accompany your expenses)

What medical coverage do you have through your/spouse/parent employment?

Name of Employer	Name of Insurer
Address of Employer	Address
City Prov. Postal Code	Policy No. Certificate

SECTION V

I hereby certify that all the information provided above is correct.

Claimant's / Guardian Signature | Date

Send completed form along with any invoices for expenses you had to pay yourself to: **All Sport Insurance Marketing Ltd.**, 417 - 1367 West Broadway, Vancouver, BC V6H 4A9 Tel: 604-737-3018 Fax: 604-737-3076 Toll: 1-877-992-2288. Please do not hesitate to call All Sport if you have any questions regarding this form. Instructions are on the reverse side. If you do not have costs at this time, please forward the form only and confirm that you intend to make a claim.

CERTIFICATION OF ASSOCIATION OR CLUB EXECUTIVE

Do not complete this section yourself; have your Club or League President, Coach or Manager complete this section.

Name of Team | League or Association

Group Policy No. | Type of Sport

Was the above player a registered member at the time of injury? Yes/No

Was the player injured while taking part in an authorized activity? Yes/No

Name | Position with Club

Telephone No. | Signature

INSTRUCTIONS

You must provide all information requested; incomplete claim forms cannot be processed.

IMPORTANT POINTS TO REMEMBER WHEN COMPLETING YOUR CLAIM:

1. Your Insurer must receive notice of your accident within 30 days of the accident date, and receive claim documentation within 90 days.

2. ALL claims must be submitted with itemized statements and paid receipts (originals are required if there is no other coverage available), which indicate:
   patient's name
   type of purchase or service
   date of each purchase or service
   amount charged for each purchase or service

3. A physician statement confirming diagnosis and recommended treatments is required if you are claiming other than dental or ambulance expense.

4. Only claims in excess of the deductible, specified in your plan details, will be considered for payment up to your maximum benefits.

5. Expenses eligible under any other health care plan(s) must be submitted to that plan(s). Your sports accident policy will pay only the amount of expenses that are not eligible with any other insurer.

• IF YOU ARE CLAIMING ANY OF THE BENEFITS LISTED BELOW, YOU MUST INCLUDE THE FOLLOWING INFORMATION WITH YOUR CLAIM:
(Please check your plan details for the conditions under which these benefits are eligible. You must have required and received medical/dental treatment commencing within 30 days of the accident date.)

• FOR BENEFITS NOT LISTED BELOW, PLEASE CONTACT THE INSURER FOR CLAIMS PROCEDURE

A. PRESCRIBED DRUGS
   -name of medication or drug
   -date of purchase
   -amount charged

B. SERVICES OF PHYSIOTHERAPIST, CHIROPRACTOR, OSTEOPATH
   -physician referral
   -type of service
   -date of each treatment
   -amount charged for each treatment
   -dates of treatments paid by Provincial Medical Plan; if private fees apply, confirming coverage has been exhausted

C. HOSPITAL ROOM ACCOMMODATION
   -not an eligible expense

D. AMBULANCE (Emergency to Hospital only)
   -date of service
   -places ambulance taken from and to
   -amount charged

E. VISION CARE
   -if your injury received medical treatment and resulted in the loss or damage of eyewear, or the requirement of eyewear due to accident
   -an explanation must be submitted with your receipt to claim the limited benefit

F. SCHEDULED FRACTURE INDEMNITY
   -if your injury results in any of the fractures or dislocations listed on the policy schedule, there may be an amount payable to you; not more than one amount (the largest) is payable.
   -a statement completed by the licensed physician or surgeon confirming the fracture/dislocation

G. MEDICAL BRACES
   -a letter from the licensed physician or surgeon indicating the diagnosis, the specific medical necessity for prescribing the brace and the type of brace prescribed, must be submitted with your receipt
   -medical braces required primarily for sporting type activities are not covered

H. DENTAL ACCIDENTS
   -exact date of accident
   -breakdown of services performed
   -circumstances surrounding the accident
   -is there other dental coverage? Enclose details
   -confirmation that treatments only relate to the accident
   -provide other insurer's explanation
   -are further treatments estimated?

I. SERVICES AVAILABLE WITHIN THE PROVINCIAL PLAN
   -your Sports Accident Policy does not make payment for any service or treatment that is available within the provincial plan, whether there is enrollment in the provincial plan or not.

YOUR SPORTS ACCIDENT POLICY MAY INCLUDE A DEDUCTIBLE AND/OR A PERCENTAGE OF REIMBURSEMENT. (Example: $100 deductible or $30 per treatment up to $300 per accident.) IF IN DOUBT, CHECK YOUR PLAN DETAILS.

ALLSPORT
INSURANCE MARKETING LTD.

417 - 1367 West Broadway
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Toll 1-877-992-2288

PART 1 DENTIST

Dentist's Name

Address

City, Province

Postal Code

Telephone

Patient's Last Name | Given Names

Address | Apt.

City, Province

Postal Code

Date of Service Day	Mo	Yr	Int. Tooth Code	Procedure Code	Tooth Surfaces	Laboratory Charge	Dentist's Fee	Total Charge

This is an accurate statement of services performed and fees charged. E. & OE.

Total Submitted Fee

Dentist's Signature

Date: Day Month Year

FOR DENTIST'S USE ONLY.
For additional information Re: diagnosis, procedures, or complications, and special considerations.

I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insuring company or its agents.

Signature of Patient (or Parent/Guardian)

I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to him.

Signature of Subscriber

FOR PLAN ADMINISTRATOR USE ONLY:

NOTICE TO DENTIST:

Please Note - Under the terms of the Policy, this report must be forwarded to the Company within 90 days of the date of the accident. Your co-operation will be appreciated.

CLAIM APPROVED:

Day Month Year Assessor

PART 2. DENTIST'S SUPPLEMENTARY REPORT

1. Description of Damage

2. Is further treatment indicated? NO ☐ YES ☐ If "Yes" please indicate:

Int. Tooth Code		Treatment Indicated – use procedure code if possible	Est. Date -Treatment Day	Mo.	Yr.

3. Describe further potential problems and indicate time frame.

Date Day Month Year

Dentist's Signature

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

ATTENDING PHYSICIAN'S STATEMENT

Please complete this claim form and return it to your patient.

Patient's Name: _____ Age: _____

Address: _____

Diagnosis: Please indicate the name(s) of the bone(s) fractured or dislocated:

_____

_____

_____

_____

_____

_____

If Hospitalized, give name of hospital: _____

Date Admitted: _____ Discharged: _____

If referred to you, give name of referring physician:

_____

Operations (or other procedures performed):

_____ Date: _____

_____ Date: _____

_____ Date: _____

Date of first consultation for above: _____

Date of first symptoms: _____ Date of Accident: _____

Has the patient ever had same or similar condition? _____

If "Yes", please state when and describe: _____

_____

Is there any other disease or infirmity affecting the present condition?

_____

Date: _____ Signature _____ (M.D.)

Address: _____

Certified Specialist _____

Phone: _____