SGHL Suspected Concussion Reporting Form

GENERAL INFORMATION

Player Name: _____ **DOB**: _____

Team Name: _____ **Position**: ☐ Forward ☐ Defense ☐ Goalie

INJURY DESCRIPTION

Date of injury: _____ **Time:**_____ **Date you were aware of suspected injury**:_____

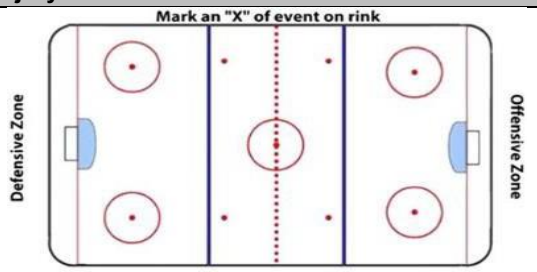
Arena: _____ **Opposing team**: _____

A) Initial injury scenario	B) Resulted in contact with	C) Was contact anticipated?
☐ Contact with Opponent	☐ Boards	☐ Yes
☐ Contact with Opponent (From Behind)	☐ Ice	☐ No
☐ Contact with Teammate	☐ Opponent's Body	☐ Unsure
☐ Fall	☐ Stick	**D) Was there a penalty called on play?**
☐ Other	☐ Puck	☐ Yes
	☐ Net	☐ No
	☐ Other	☐ Unsure

E) Game Scenario	F) Period	G) Puck Possession
☐ On ice practice	☐ 1st period	☐ Yes
☐ Regular game	☐ 2nd period	☐ No
☐ Exhibition	☐ 3rd period	☐ Just released
☐ Tournament	☐ Overtime	☐ Other
☐ Playoffs	☐ Other	
☐ Other _____		

Additional Comments:

I) Injury Location



REPORTED SYMPTOMS (*CHECK ALL THAT APPLY*)

☐ Visual problems	☐ Balance problems	☐ Drowsiness	☐ Irritability
☐ Nausea	☐ Feeling mentally foggy	☐ Sleeping more/less than usual	☐ Sadness
☐ Dizziness	☐ Feeling slowed down	☐ Trouble falling asleep	☐ Nervous/anxious
☐ Vomiting	☐ Difficulty concentrating	☐ Sensitive to light	☐ More emotional
☐ Headache	☐ Difficulty remembering	☐ Sensitive to noise	☐ Fatigue

RED FLAG SYMPTOMS (*CHECK ALL THAT APPLY): CALL 911 IMMEDIATELY WITH A SUDDEN ONSET OF ANY OF THESE SYMPTOMS*

☐ Severe or worsening headache	☐ Neck pain or tenderness	☐ Seizure or convulsion
☐ Double vision	☐ Loss of consciousness	☐ Repeated vomiting
☐ Weak/numb or tingling/burning in arms/legs	☐ Deteriorating conscious state	☐ Increasingly restless, agitated or combative
☐ Slurred speech	☐ Worsening confusion	

Are there any <u>other</u> symptoms or evidence of injury to anywhere else? ☐Yes ☐No
If yes, what: _____

Has this player had a concussion before? ☐Yes ☐No ☐Prefer not to answer If yes, how many: ☐1 ☐2 ☐3 ☐4 ☐>5 ☐Unsure

Any pre-existing medical conditions or take any medications? ☐Yes ☐No ☐Prefer not to answer
If yes, please list:_____

I [*name of coach completing this form*] _____recommended to player's parent/guardian that the player seek medical assessment as soon as possible. *A medical assessment must be from a physician (i.e., family doctor, pediatrician, emergency room doctor, sports-medicine physician, physiatrist, neurologist) or a nurse practitioner.*

Signature_____ Phone Number: _____

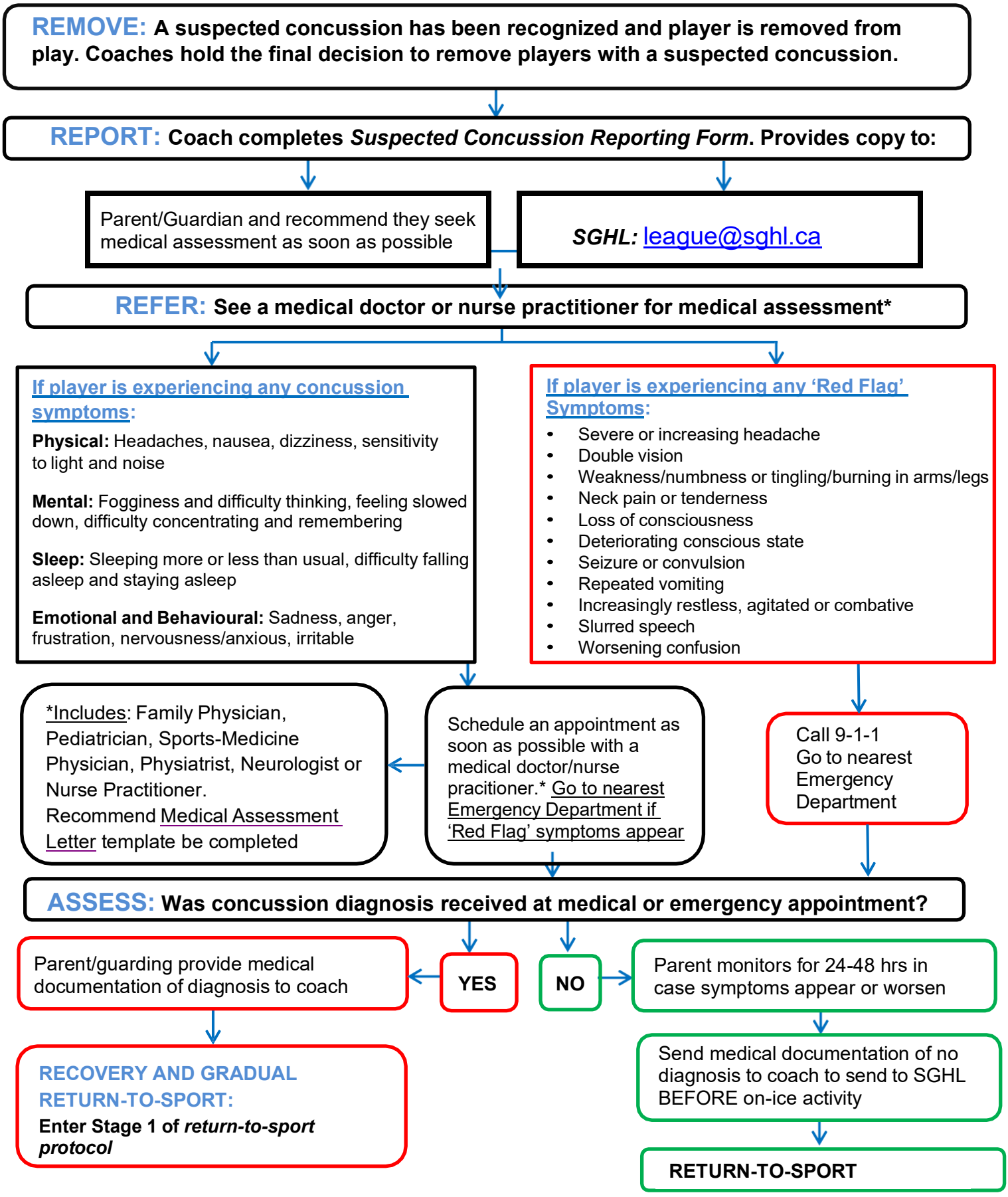
Email Address:_____

PLEASE NOTE: *This form is to be completed by the team coach in the event of a suspected concussion in any SGHL activity. Once complete, give one copy of this report to parent/guardian and the other to SGHL Director of Health & Safety* ***EMAIL:*** league@sghl.ca. ***Parents and players are to take this form to a medical assessment appointment.***

Report form informed by the GTHL Suspected Concussion Report Form & Living Guideline for Pediatric Concussion Care

Version Oct 2025

Figure 1. Remove-From-Sport Protocol Summary



Informed by the GTHL Remove-from-sport Protocol Summary & Living Guideline for Pediatric Concussion Care

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