Hamilton Ultimate Club Suspected Concussion Report Form

Player Name: ______________________________ Date of Birth: ______________________________

Date & Time of Injury: ______________________ Team Name: ______________________________

League/Session/Event: ______________________ Game/Session Location: ______________________

Injury Description:

Reported Symptoms (Check all that apply):

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

Red Flag Symptoms (Check all that apply): Call 911 immediately with a sudden onset of any of these symptoms

☐ Headache that worsens	☐ Can't recognize people or places	**Was 911 called?**
☐ Seizures or convulsions	☐ Increasing confusion or irritability	
☐ Repeated vomiting	☐ Weakness or numbness in arms/legs	☐ Yes
☐ Loss of consciousness	☐ Persistent or increasing neck pain	
☐ Looks very drowsy/can't be awakened	☐ Unusual behavior change	☐ No
☐ Slurred speech	☐ Focal neurological signs (e.g. paralysis, weakness, etc.)	

Are there any <u>other</u> observable/reported symptoms? ☐ Yes ☐ No

If yes, what: ____

Is there evidence of injury to anywhere else on the body besides the head? ☐ Yes ☐ No

If yes, where: ____

Has this player had a concussion before? ☐ Yes ☐ No ☐ Prefer not to answer

If yes, how many: ____

Does this player have any pre-existing medical conditions? ☐ Yes ☐ No ☐ Prefer not to answer

If yes, please list: ____

Does this player take any medication? ☐ Yes ☐ No ☐ Prefer not to answer

If yes, please list: ____

I [name of Most Responsible Adult completing this form], ______________________________ recommended to the player (or guardian if the player is under 18 years of age) that they see a medical professional immediately. A medical professional includes a medical doctor, family doctor, pediatrician, emergency room doctor, sports-medicine physician, neurologist or nurse practitioner.

Signature: ____________________ Date: ______________________ Role: ______________________

PLEASE NOTE: This form is to be completed by the Most Responsible Adult in the event of a <u>suspected</u> concussion in <u>*any Hamilton Ultimate (HUC) activity*</u>. Once this form is complete, give one copy of this report to the participant and the other to the HUC General Manager.
EMAIL: admin@hamiltonultimate.com. The Most Responsible Adult is to provide this form for a medical professional immediately.
***Please review HUC's Concussion Policy for the list of appropriate medical professionals for the diagnosis.**