CONCUSSION INCIDENT REPORT

Please fill out the document below:

This incident form was completed by:

NAME: _____

CONTACT INFORMATION: _____

_____

_____

Did you witness the event?

☐ Yes

☐ No

NAME AND CONTACT OF ADDITIONAL WITNESSES:

_____

_____

_____

ORGANIZATION: _____

DATE (DD/MM/YYYY): _____

Please indicate who you are completing this report for; who will receive this incident report? Please check all that apply:

☐ Injured person

☐ Emergency contact

☐ Ambulance attendant

☐ ER physician

☐ Supervisor/Employer

☐ Teacher/School

☐ Coach/Sports organization

☐ Other (write below):

ABOUT THE INCIDENT

DATE OF INCIDENT (DD/MM/YYYY): _____

TIME OF INCIDENT: _____ ☐ AM ☐ PM

NAME OF INJURED PERSON : _____

CONTACT INFO OF INJURED PERSON:

_____

_____

LOCATION OF INCIDENT: _____

NAME OF EMERGENCY CONTACT: _____

CONTACT INFO OF EMERGENCY CONTACT: _____

_____

_____

Describe the incident. Please include as much detail as possible:

_____

_____

_____

_____

_____

Did the incident involve any of the following? Please check all that apply:

☐ Blow to the head

☐ Hit to the body

☐ Assault

☐ Motor vehicle collision

☐ Fall

☐ Struck by object

☐ Struck by person

☐ Sport-related

☐ Other:

Continue to document the incident on next page >>

What was the immediate response to the incident? Please check all that apply:

- ☐ Called 911
- ☐ Called emergency contact
- ☐ Performed first aid
- ☐ No response
- ☐ Other:

What was the immediate outcome of the incident? Please check all that apply:

- ☐ Taken to hospital by ambulance
- ☐ Attended to by paramedics
- ☐ Left with emergency contact
- ☐ Left independently
- ☐ Returned to activity
- ☐ Other:

Did the person exhibit any immediate signs or symptoms of concussion?

☐ Yes ☐ No ☐ Don't know

If yes, check all that apply:

- ☐ Neck pain or tenderness
- ☐ Double Vision
- ☐ Weakness or numbness in arms or legs
- ☐ Severe or increasing headache
- ☐ Seizures
- ☐ Severe drowsiness or can't be awakened
- ☐ Decreasing consciousness, loss of consciousness
- ☐ Vomiting
- ☐ Repeating questions
- ☐ Bruising behind the ears
- ☐ Inability to remember more than 30 minutes before OR after injury
- ☐ Unusual behaviour
- ☐ Two black eyes

- ☐ Headache
- ☐ Nausea
- ☐ Balance problems
- ☐ Feeling slowed down
- ☐ Difficulty concentrating
- ☐ Confusion
- ☐ More emotional
- ☐ Nervous or anxious
- ☐ Pressure in head
- ☐ Dizziness
- ☐ Sadness

- ☐ Sensitivity to light
- ☐ Sensitivity to noise
- ☐ Feeling like they're "in a fog"
- ☐ Difficulty remembering
- ☐ Drowsiness
- ☐ Irritability
- ☐ Neck pain
- ☐ Blurred vision
- ☐ "Don't feel right"
- ☐ Fatigue or low energy
- ☐ Trouble falling asleep

IF ANY OF THE SYMPTOMS IN COLUMN 1 ARE PRESENT, CALL 911

To be filled out by administration only

Did this incident result in a concussion diagnosis?

☐ Yes ☐ No ☐ Don't know

Please describe any follow-up actions that have been taken (e.g., safety risk assessment):

_____

_____

_____

_____

_____

_____

_____

_____

Could this incident have been prevented?

☐ Yes ☐ No ☐ Don't know

Please describe how this incident could or could not have been prevented: _____

_____

_____

_____

Please describe any follow-up actions that are needed (e.g., systemic actions to ensure health and safety): _____

_____

_____

_____