

# CONCUSSION INCIDENT REPORT



Please fill out the document below:

## This incident form was completed by:

NAME: \_\_\_\_\_

ORGANIZATION: \_\_\_\_\_

CONTACT  
INFORMATION: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATE (DD/MM/YYYY): \_\_\_\_\_

**Did you  
witness the  
event?**

☐ Yes

☐ No

NAME AND CONTACT OF ADDITIONAL  
WITNESSES:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

☐ Injured person

☐ Supervisor/Employer

☐ Emergency contact

☐ Teacher/School

☐ Ambulance attendant

☐ Coach/Sports organization

☐ ER physician

☐ Other (write below):

## ABOUT THE INCIDENT

DATE OF INCIDENT (DD/MM/YYYY): \_\_\_\_\_

LOCATION OF INCIDENT: \_\_\_\_\_

TIME OF INCIDENT: \_\_\_\_\_ ☐ AM ☐ PM

NAME OF  
EMERGENCY CONTACT: \_\_\_\_\_

NAME OF INJURED PERSON : \_\_\_\_\_

CONTACT INFO OF INJURED PERSON:

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

☐ Motor vehicle collision

☐ Struck by person

☐ Hit to the body

☐ Fall

☐ Sport-related

☐ Assault

☐ Struck by object

☐ 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:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Neck pain or tenderness   | <input type="checkbox"/> Headache                 | <input type="checkbox"/> Sensitivity to light            |
| <input type="checkbox"/> Double Vision   | <input type="checkbox"/> Nausea                   | <input type="checkbox"/> Sensitivity to noise            |
| <input type="checkbox"/> Weakness or numbness in arms or legs                              | <input type="checkbox"/> Balance problems         | <input type="checkbox"/> Feeling like they're "in a fog" |
| <input type="checkbox"/> Severe or increasing headache                                     | <input type="checkbox"/> Feeling slowed down      | <input type="checkbox"/> Difficulty remembering          |
| <input type="checkbox"/> Seizures  | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Drowsiness                      |
| <input type="checkbox"/> Severe drowsiness or can't be awakened                            | <input type="checkbox"/> Confusion                | <input type="checkbox"/> Irritability                    |
| <input type="checkbox"/> Decreasing consciousness, loss of consciousness                   | <input type="checkbox"/> More emotional           | <input type="checkbox"/> Neck pain                       |
| <input type="checkbox"/> Vomiting  | <input type="checkbox"/> Nervous or anxious       | <input type="checkbox"/> Blurred vision                  |
| <input type="checkbox"/> Repeating questions   | <input type="checkbox"/> Pressure in head         | <input type="checkbox"/> "Don't feel right"              |
| <input type="checkbox"/> Bruising behind the ears  | <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Fatigue or low energy           |
| <input type="checkbox"/> Inability to remember more than 30 minutes before OR after injury | <input type="checkbox"/> Sadness                  | <input type="checkbox"/> Trouble falling asleep          |
| <input type="checkbox"/> Unusual behaviour   |   |  |
| <input type="checkbox"/> Two black eyes  |   |  |

**\*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):**

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**Could this incident have been prevented?**

- ☐ Yes
- ☐ No
- ☐ Don't know

**Please describe how this incident could or could not have been prevented:** \_\_\_\_\_

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

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