PLAYER - SERIOUS INJURY REPORT

Player Information:

First Name: _____ Address: _____

Last Name: _____ City: _____

Birthday (mm/dd/yy): _____ Postal Code: _____ Phone: _____

Care Card #: _____ Email: _____

Incident Details:

Name of Reporter: _____ Phone: _____ Email: _____

Date of Incident: _____ Coach: _____ Team: _____

Incident Location: _____

Please detail the the inury / incident in the area below:

911 / Ambulance / EMS

☐ 911 Called? ☐ Ambulance attended? ☐ EMS Staff treated player? ☐ Player transported by Ambulance?

Details of actions taken at the time of the injury / incident:

Head Injury - Please complete if this was a suspected Concussion

☐ Concussion suspected? ☐ Concussion protocal tested at field? ☐ Player removed from play?

CONCUSSION QUICK ASSESSMENT GUIDELINE

RECOGNIZE & REMOVE

Concussion should be suspected if one or more of the following visible clues, signs, symptoms or errors in memory questions are present.

Visible clues of suspected concussion: Any one or more of the following visual clues can indicate a possible concussion.

- Loss of consciousness or responsiveness
- Lying motionless on ground / Slow to get up
- Unsteady on feet / Balance problems or falling over / Incoordination
- Grabbing / Clutching of head
- Dazed, blank or vacant look
- Confused / Not aware of plays or events
- Please see a more detailed SCAT testing online: http://www.fifa.com/about-fifa/official-documents/development/index.html#medical