

CONCUSSION INCIDENT FORM

INCIDENT REPORT FORM

Participant Information		Date:	
Last Name:		First Name:	
Phone:		Province:	
Gender	Girl / Woman <input type="checkbox"/> Boy/ Man <input type="checkbox"/> Non-binary person (including agender, genderqueer, genderfluid and bi/polygender) <input type="checkbox"/> Prefer not to say <input type="checkbox"/>	Age:	
Club / League:			
Relevant other medical conditions			

INCIDENT INFORMATION REPORT

Date of incident:			
Time of first intervention:			
Time of medical support:			
Describe the incident			
Conditions: (describe any significant information like surface quality):			
Actions Taken:			
After intervention, the individual was:	<input type="checkbox"/> sent home	<input type="checkbox"/> sent to hospital	<input type="checkbox"/> back on the ice
Form completed by:			
Print			
Date	Signature		

Information provided in this form will remain private and confidential.

COMPLETED FORMS MUST BE SUBMITTED TO RINGETTE CANADA ringette@ringette.ca