Concussion Management Incident Report

Date/Time of Incident _____ _____ am/pm
Location of Incident _____
Name of player _____ Team: BU/GU _____
Name of Coach _____
Name of Report Preparer (if not Coach) _____

1. Injury Description:
   a. Cause of injury and force of hit or blow to head (direct or indirect)
   _____
   _____
   _____

   b. Location of impact? ___Front ___ Left Side ___ Right Side ___Back

2. Any loss of consciousness (Yes /No /NA)? If so, how long? _____

3. Amnesia Before Injury: ___ Yes ___ No

4. Amnesia After Injury: ___ Yes ___ No

5. Early Signs: ___Appears dazed or stunned ___ Is confused about events ___Answers questions slowly ___Repeats Questions ___ Forgetful

6. Seizures: ___ No ___ Yes. Details _____

_____ _____
Signature & printed name of Report Preparer Date

_____ _____
Signature & printed name of Additional Witness Date

COPIES OF REPORT PROVIDED TO:	
☐ Player Parent/Guardian	Date: _____
☐ Coaching Director	Date: _____
☐ Club Concussion Administrator	Date: _____