Ohio Champions League Suspected Concussion Form

This form must be completed within four hours of the completion of a game.

Player Name: _____

Player's Team: _____

Player's Date of Birth: _____

Opposing Team: _____

Field Complex: _____

Field Number: _____

Time of Game: _____

Time of the Injury (Actual Time): _____

Time of the Injury (Time into Game): _____

Name of Individual Identifying the Injury: _____

Role of Individual Identifying the Injury: _____

Cell Phone Number of Identifying Individual: _____

E-Mail Address of Identifying Individual: _____

Name of Player's Head Coach: _____

Cell Phone Number of Player's Head Coach: _____

E-Mail Address of Player's Head Coach: _____

Name of Player's Parent: _____

Cell Phone Number of Player's Parent: _____

E-Mail Address of Player's Parent: _____

Description of Incident Causing the Potential Concussion: _____

_____

_____

_____

Scan and E-mail this form to ohiochampionsleague@gmail.com with subject: Suspected Concussion Form.