



INJURY REPORTING FORM



One form must be completed for each "injury" is defined as: Any ice hockey related ailment, occurring on the rink or player's bench, that kept (or would have kept) a player out of practice or competition for 24 hours or required medical attention (trainer, nurse or doctor) and all concussions, lacerations (cuts), dental, eye and nerve injuries.

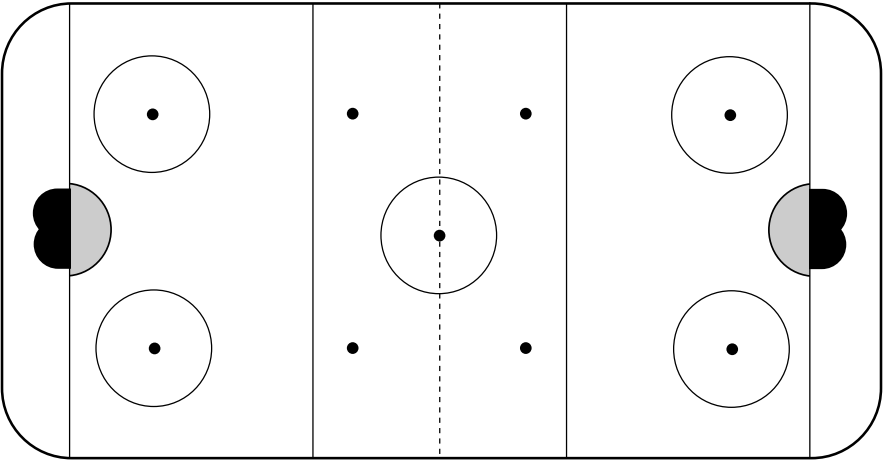
Name _____ Date of Injury ____-____-____ Trainer/MD Name _____

Street Address _____

City _____ State _____ Zip Code _____

Position played at time of injury (W, C, D, G) _____ Game opponent (team) _____

Time of injury (Warm-ups, 1, 2, 3, OT, After) _____ Game frequency (1st, 2nd, 3rd, etc. game of event) _____

<p>TYPE OF INJURY</p> <p><input type="checkbox"/> Contusion <input type="checkbox"/> Fracture</p> <p><input type="checkbox"/> Laceration <input type="checkbox"/> Dislocation</p> <p><input type="checkbox"/> Strain <input type="checkbox"/> Concussion</p> <p><input type="checkbox"/> Sprain</p> <p><input type="checkbox"/> Other _____</p> <p>_____</p>	<p>BODY PART AFFECTED (Check the affected areas and indicate left or right side)</p> <p><input type="checkbox"/> Head/Scalp <input type="checkbox"/> Chest</p> <p><input type="checkbox"/> Face/Nose <input type="checkbox"/> Abdomen</p> <p><input type="checkbox"/> Eye(s) <input type="checkbox"/> Back/Spine</p> <p><input type="checkbox"/> Mouth/Teeth <input type="checkbox"/> Buttocks</p> <p><input type="checkbox"/> Neck/Ear <input type="checkbox"/> Groin</p> <p><input type="checkbox"/> Shoulder <input type="checkbox"/> Hip</p> <p><input type="checkbox"/> Arm/Elbow <input type="checkbox"/> Leg/Knee</p> <p><input type="checkbox"/> Wrist <input type="checkbox"/> Ankle</p> <p><input type="checkbox"/> Hand/Finger <input type="checkbox"/> Foot/Toe</p>	<p>INJURED'S CATEGORY</p> <p><input type="checkbox"/> Player <input type="checkbox"/> Coach</p> <p><input type="checkbox"/> Referee <input type="checkbox"/> Manager</p> <p><input type="checkbox"/> Volunteer <input type="checkbox"/> Spectator</p> <p><input type="checkbox"/> Other _____</p> <p>INTENT TO INJURE? (according to injured player)</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PENALTY CALLED?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>NEW INJURY?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>HOW INJURY OCCURRED</p> <p><input type="checkbox"/> Contact with boards</p> <p><input type="checkbox"/> Contact with goal/net</p> <p><input type="checkbox"/> Body contact with another person</p> <p> <input type="checkbox"/> Caused by a body check</p> <p> <input type="checkbox"/> Incidental to playing puck/ball</p> <p><input type="checkbox"/> Struck by a stick</p> <p><input type="checkbox"/> Contact with skate</p> <p><input type="checkbox"/> Contact with floor</p> <p><input type="checkbox"/> Struck by puck</p> <p><input type="checkbox"/> No apparent contact</p> <p><input type="checkbox"/> Other _____</p> <p>_____</p>	<p>LOCATION (X on diagram where injury occurred)</p>  <p>Please indicate the injured player's defending goal</p>	

Brief description of injury (what happened): _____

What action was taken for injury? _____

Name of Person Treating _____ Phone _____