



INJURY REPORTING FORM



One form must be completed for each "injury" is defined as: Any ice hockey or inline 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) _____

TYPE OF INJURY

- | | |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Contusion | <input type="checkbox"/> Fracture |
| <input type="checkbox"/> Laceration | <input type="checkbox"/> Dislocation |
| <input type="checkbox"/> Strain | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Sprain | |
| <input type="checkbox"/> Other _____ | |

BODY PART AFFECTED

(Check the affected areas and indicate left or right side)

- | | |
|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Head/Scalp | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Face/Nose | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Eye(s) | <input type="checkbox"/> Back/Spine |
| <input type="checkbox"/> Mouth/Teeth | <input type="checkbox"/> Buttocks |
| <input type="checkbox"/> Neck/Ear | <input type="checkbox"/> Groin |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Arm/Elbow | <input type="checkbox"/> Leg/Knee |
| <input type="checkbox"/> Wrist | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Hand/Finger | <input type="checkbox"/> Foot/Toe |

INJURED'S CATEGORY

- | | |
|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Player | <input type="checkbox"/> Coach |
| <input type="checkbox"/> Referee | <input type="checkbox"/> Manager |
| <input type="checkbox"/> Volunteer | <input type="checkbox"/> Spectator |
| <input type="checkbox"/> Other _____ | |

INTENT TO INJURE?

(according to injured player)

- ☐ YES ☐ NO

PENALTY CALLED?

- ☐ YES ☐ NO

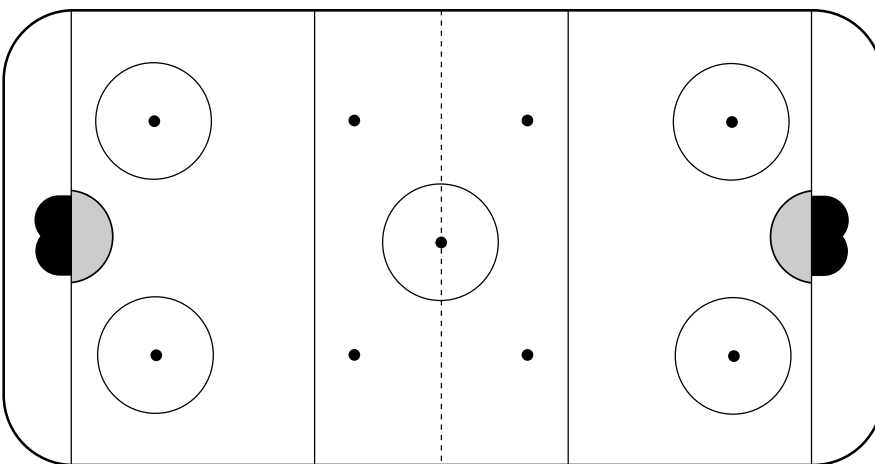
NEW INJURY?

- ☐ YES ☐ NO

HOW INJURY OCCURRED

- ☐ Contact with boards
- ☐ Contact with goal/net
- ☐ Body contact with another person
- ☐ Caused by a body check
- ☐ Incidental to playing puck/ball
- ☐ Struck by a stick
- ☐ Contact with skate
- ☐ Contact with floor
- ☐ Struck by puck/ball
- ☐ No apparent contact
- ☐ Other _____

LOCATION (X on floor where injury occurred)



Please indicate the injured player's defending goal

Brief description of injury (what happened) _____

What action was taken for injury? _____

Name of Person Treating _____ Phone _____