



## Ontario Amateur Softball Association Suspected Concussion Report Form

Player Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date & Time of Injury: \_\_\_\_\_

Club Name: \_\_\_\_\_

Division: \_\_\_\_\_ Level: \_\_\_\_\_

Game/Practice Location: \_\_\_\_\_

### Injury Description

### Reported Symptoms (Check all that apply):

<input type="checkbox"/> Headache	<input type="checkbox"/> Feeling mentally foggy	<input type="checkbox"/> Sensitive to light
<input type="checkbox"/> Nausea	<input type="checkbox"/> Feeling slowed down	<input type="checkbox"/> Sensitive to noise
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Irritability
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Difficulty remembering	<input type="checkbox"/> Sadness
<input type="checkbox"/> Visual problems	<input type="checkbox"/> Drowsiness	<input type="checkbox"/> Nervous/anxious
<input type="checkbox"/> Balance problems	<input type="checkbox"/> Sleeping more/less than usual	<input type="checkbox"/> More emotional
<input type="checkbox"/> Numbness/tingling	<input type="checkbox"/> Trouble falling asleep	<input type="checkbox"/> Fatigue

### Red Flag Symptoms (Check all that apply): Call 911 immediately with a sudden onset of any of these symptoms

<input type="checkbox"/> Headache that worsen	<input type="checkbox"/> Can't recognize people or places	<b>Was 911 Called?</b>  <input type="checkbox"/> Yes  <input type="checkbox"/> No
<input type="checkbox"/> Seizures or convulsions	<input type="checkbox"/> Increasing confusion or irritability	
<input type="checkbox"/> Repeated Vomiting	<input type="checkbox"/> Weakness or numbness in arms/legs	
<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Persistent or increasing neck pain	
<input type="checkbox"/> Looks very drowsy/can't be awakened	<input type="checkbox"/> Unusual behavioural change	
<input type="checkbox"/> Slurred speech	<input type="checkbox"/> Focal neurologic signs (e.g. paralysis, weakness, etc.)	

**Are there any other observable/reported symptoms:** Yes  No

If yes, what: \_\_\_\_\_

**Is there evidence of injury to anywhere else on body besides head?:** Yes  No

If yes, where: \_\_\_\_\_

**Has this player had a concussion before?:** Yes  No  Prefer not to answer

If yes, how many: \_\_\_\_\_

**Does this player have any pre-existing medical conditions?:** Yes  No  Prefer not to answer

If yes, please list: \_\_\_\_\_

**Does this player take any medication?** Yes  No  Prefer not to answer

If yes, please list: \_\_\_\_\_

**I [name of trainer completing this form]:** \_\_\_\_\_ **recommended to the player's parent or guardian that the player sees a medical professional immediately. A medical professional includes a medical doctor, family doctor, pediatrician, emergency room doctor, sports-medicine physician, neurologist or nurse practitioner.**

Signature \_\_\_\_\_ Date: \_\_\_\_\_ Team Official Role: \_\_\_\_\_

**PLEASE NOTE:** This form is to be completed by the team trainer in the event of a suspected concussion in any Ontario Amateur Softball Association activity. Once this form is complete, give one copy of this report to parent/guardian and the other to the Ontario Amateur Softball Association head offices, EMAIL: [dave.northern1@gmail.com](mailto:dave.northern1@gmail.com). Parents are to take this form to a medical professional immediately.

\* Please review Ontario Amateur Softball Association Concussion Policy for list of appropriate medical professionals for diagnosis.