

GA GUARDIANS FOOTBALL

Faith. Character. Competition.

CONCUSSION INCIDENT REPORT FORM

CONFIDENTIAL — Complete Immediately After Suspected Head Injury

■ IF ATHLETE IS UNRESPONSIVE, SEIZING, OR CANNOT WALK — CALL 911 IMMEDIATELY ■

SECTION 1 — INCIDENT INFORMATION

Date of Incident:

Time: AM / PM

Location / Venue (full address if possible):

Sport / Activity:

Opposing Team (if game):

Practice or Game: Practice Game Scrimmage Other

Surface / Field Type:

SECTION 2 — ATHLETE INFORMATION

Athlete Full Legal Name:

Date of Birth:

School / Organization:

Grade: Jersey/ID #:

Parent/Guardian Name:

Emergency Phone:

Prior Concussion History: None 1 Prior 2 Prior 3+ Unknown

SECTION 3 — MECHANISM OF INJURY

- | | | |
|---------------------------------------------------------|------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Helmet-to-Helmet contact | <input type="checkbox"/> Head-to-Ground / Fall | <input type="checkbox"/> Elbow/Knee/Shoulder to Head |
| <input type="checkbox"/> Head-to-Goalpost / Wall | <input type="checkbox"/> Head-to-Ball | <input type="checkbox"/> Body contact — indirect force |
| <input type="checkbox"/> Whiplash / rapid head rotation | <input type="checkbox"/> Unknown mechanism | |

Describe exactly what happened (include impact direction, player positions, context):

SECTION 4 — SIGNS & SYMPTOMS OBSERVED

RED FLAG SYMPTOMS — Any of these = activate EMS immediately:

- | | | |
|------------------------------------------------|------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Seizure / Convulsions | <input type="checkbox"/> Cannot walk normally |
| <input type="checkbox"/> Repeated vomiting | <input type="checkbox"/> Unequal pupils | <input type="checkbox"/> Increasing confusion/agitation |
| <input type="checkbox"/> Slurred speech | <input type="checkbox"/> Extreme drowsiness | <input type="checkbox"/> Neck pain with arm numbness |

General Symptoms:

- | | | | |
|--------------------------------------------|--------------------------------------------|----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pressure in head | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Noise sensitivity | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Balance problems |
| <input type="checkbox"/> Feeling slowed | <input type="checkbox"/> Feeling foggy | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Drowsiness | <input type="checkbox"/> More emotional |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Sadness / Anxiety | <input type="checkbox"/> Numbness / Tingling | <input type="checkbox"/> Feeling 'not right' |

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SECTION 5 — IMMEDIATE ACTIONS TAKEN

- | | | |
|------------------------------------------------------------|---------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Removed athlete from play | <input type="checkbox"/> Monitored athlete on-site | <input type="checkbox"/> EMS / 911 activated |
| <input type="checkbox"/> Parent/Guardian notified by phone | <input type="checkbox"/> School administration notified | <input type="checkbox"/> Athletic trainer assessed athlete |
| <input type="checkbox"/> Team physician evaluated | <input type="checkbox"/> Ice / cold compress applied | <input type="checkbox"/> Athlete transported to ER |
| <input type="checkbox"/> Athlete sent home with parent | <input type="checkbox"/> Athlete remained on-site | <input type="checkbox"/> Concussion protocol initiated |

Time removed from play: _____

Time parent notified: _____

Medical personnel who assessed athlete: _____

Hospital / ER (if transported): _____

SECTION 6 — REPORT COMPLETED BY

Reporting Staff Member (Print): _____

Title / Role: _____

Phone: _____

Email: _____

Signature: _____

Date: _____

Athletic Trainer / Physician Confirmation — Signature: _____

SECTION 7 — DISTRIBUTION & FOLLOW-UP CHECKLIST

- | | | |
|-------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Athletic Director | <input type="checkbox"/> School Principal / Administrator | <input type="checkbox"/> School Nurse / Health Office |
| <input type="checkbox"/> Head Coach | <input type="checkbox"/> Parent/Guardian (copy given) | <input type="checkbox"/> Treating Physician |
| <input type="checkbox"/> Original filed in athlete medical record | <input type="checkbox"/> | <input type="checkbox"/> |

Physician follow-up scheduled? Yes — Date: _____ No — Reason: _____

Return-to-Learn accommodations initiated? Yes No

Concussion Return-to-Play Protocol initiated? Yes — Date: _____ No

ATHLETE MUST NOT RETURN TO PLAY ON THE DAY OF INJURY — Initiate Return-to-Play Protocol before any return