



UOVLL Suspected Concussion Report Form

Player Name: _____ DOB: _____

Date & Time of Injury: _____ Team Name: _____

Division: _____ 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"/> Fatigue	<input type="checkbox"/> More emotional
<input type="checkbox"/> Numbness/tingling		

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

<input type="checkbox"/> Headache that worsens	<input type="checkbox"/> Can't Recognize People or places	Was 911 Called? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Seizures or convulsions	<input type="checkbox"/> Increasing Confusion/Irritability	
<input type="checkbox"/> Repeated Vomiting	<input type="checkbox"/> Weakness/Numbness in Arms/Legs	
<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Persistent/Increasing Neck Pain	
<input type="checkbox"/> Looks 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)	

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 _____ recommended to the player's parent or guardian that the player sees a medical professional immediately. A medical professional includes a nurse practitioner or medical doctor such as family doctor, pediatrician, emergency room doctor, sports-medicine physician, neurologist.

Signature: _____ Signature Date: _____ Team Official Role: _____

PLEASE NOTE: This form is to be completed by the team manager/coach in the event of a suspected concussion in any Upper Ottawa Valley Little League (UOVLL) activity. Once this form is complete, give one copy of this report to parent/guardian and email a copy to safety@uovll.ca Parents are to take this form to a medical professional immediately

