

## **SPORTS INJURY REPORT FORM**

INTERNATIONAL SOCCER CLUB 3176 Pebblewood Mississauga, ON L5N 6P4 Tel: (416) 277-2303

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This form is to be completed by a Coach or Club Official at the time of injury

## **SUBMIT THIS FORM TO:**

A Club Official at the Clubhouse
Within 2 DAYS of the injury occurrence.

| Field/ Facility:   | First Name:  | Last Name:           |   | Date of Injury:   |                              |  |
|--|--|----------------------|---|-------------------|------------------------------|--|
| SECTION 8:   DETAILS OF INJURY   Injured Parts   Constact Not      | Address:   | City:                | Prov:   | Phone I           | No: ()                       |  |
| Coach   Other  |  |                      |   |                   |                              |  |
| (1st) Witness:   |  |                      |   |                   |                              |  |
| Contact No:   Contact No:   Contact No:   Contact No:   Contact No:   Contact no finjury:   Outdoor Field   Paramount SportsZone   School   Stands/ Dressing Room   Other   Field/ Facility:   Team Name:   League Name/Event:   Completed By:   Phone No:   Pho   | SECTION A: PERSON INJURED  | ☐ Player             | ☐ Official  | ☐ Coach           | ☐ Other                      |  |
| Completed By:  | (1st) Witness:   | (Full Name) <b>F</b> | Position:   | Contact           | : No: ()                     |  |
| Field/ Facility:   |  |                      |   |                   |                              |  |
| Position:  | <b>Location of Injury</b> : ☐ Outdoor Field ☐ Paramount SportsZone ☐ School ☐ Stands/ Dressing Room ☐ Other  |                      |   |                   |                              |  |
| Type of Activity:   League Game   H. L. Game   Team Practice   Tournament   Central H.L. Training   ADP   Other Injury Occurred During:   Pre-Season   Outdoor Season   Playoffs   Indoor Season   Post-Season   Playoffs   Indoor Season   Playoffs   Indoor Season   Post-Season   Playoffs   Indoor Season   Indoor Season  | Field/ Facility: Team Name: League Name/Event:   |                      |   |                   |                              |  |
| Injury Occurred During: Pre-Season   Outdoor Season   Playoffs   Indoor Season   Post-Season    PLEASE COMPLETE SECTION "A" ABOVE IN FULL AND AS MUCH OF SECTION "B" BELOW AS POSSIBLE  SECTION B: DETAILS OF INJURY (INDICATE & ATTACH ADDITIONAL SCHEDULES, IF NECESSARY)    Injured Party:   Male   Female   Date of Birth:   (Day/Mth./Yr.)  | Completed By:  | Position:            |   | Phone No: (       | )                            |  |
| Please circle and indicate the injury and if it could have been avoided:    Please circle and indicate the injury and if it could have been avoided:    Please indicate in the diagram where the injury occurred:   Please indicate in the injury oc   | <b>Type of Activity:</b> ☐ League Game ☐ H. L. Game ☐ Team Practice ☐ Tournament ☐ Central H.L. Training ☐ ADP ☐ Other  Injury Occurred During: ☐ Pre-Season ☐ Outdoor Season ☐ Playoffs ☐ Indoor Season ☐ Post-Season |                      |   |                   |                              |  |
| Injured Party:   Male   Female   Date of Birth:   (Day/Mth./Yr.)   Weight (flbs):   Height (flt./in.):   Anticipated Injury Time Loss:   0 Days   1-5 Days   5-10 Days   10+   Nature of Injury:   Facature   Laceration   Skin Injury   Recurring Injury   Other (Specify)   Injury Type:   Contact   Symptoms:   Loss of Feeling   Pain   Dizziness   Shortness of Breath   Other (Specify)   Shortness of Breath   Other (Specify)   Treated and indicate the injury and if it could have been avoided:   First Aid/Care:   Trainer   Hospital   EMS   Family Dr.   Coach   Other (Specify)   Injury Type:   Contact   Symptoms:   Loss of Consciousness of Family Dr.   Coach   Other (Specify)   Treated at Hospital, party transported by   Ambulance   Private Vehicle Driver:   Caregiver:   (If known)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   CPR   Stretching   Manual Therapy   Dressing   Wrapping/Taping   Sling/Splint   None   Was injured Party wearing any protective equipment or other devices, shin guards, glasses, other personal equipment?   Yes   No Please describe:   Signature & Name of Insurance Company:   SIGNATURE & NAME OF WITNESS:   SIGNATURE & NAME OF WITNESS:   |  |                      |   |                   |                              |  |
| Injured Party:   Male   Female   Date of Birth:   (Day/Mth./Yr.)   Weight (lfb.):   Height (ft./in.):   Anticipated Injury Time Loss:   0 Days   1-5 Days   5-10 Days   10+   Nature of Injury:   Freezame   Lower Back   Nature of Injury:   Freezame   Laceration   Skin Injury   Recurring Injury   Other (Specify)   Injury Type:   Contact   Non-Contact   Symptoms:   Loss of Feeling   Pain   Dizziness   Shortness of Breath   Other (Specify)   Strate below what caused the injury and if it could have been avoided:   First Aid/Care:   Trainer   Hospital   EMS   Family Dr.   Coach   Other (Specify)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   Other (Specify)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   Other (Specify)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   Other (Specify)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   Other (Specify)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   Other (Specify)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   Other (Specify)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   Other (Specify)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   Other (Specify)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   Other (Specify)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   Other (Specify)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   Other (Specify)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   Other (Specify)   Other (Specify)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   Other (Specify)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   Other (Specify)   Other (Specify)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   Other (Specify)   Other (Specify | SECTION B: DETAILS OF INJURY   | (INDICATE &          | ATTACH ADDITION   | AL SCHEDULES      | . IF NECESSARY)              |  |
| Weight (lbs):  |  |                      |   |                   |                              |  |
| Anticipated Injury Time Loss:   0 Days   1-5 Days   5-10 Days   10+    Nature of Injury:   Fracture   Laceration   Sprain/ Strain   Head Injury     Dislocation   Skin Injury   Recurring Injury     Other (Specify)   |  | III -                | -   |                   |                              |  |
| Gracture   Laceration   Sprain/ Strain   Head Injury   Other (Specify)   Other (Sp   | Right  |                      |   |                   |                              |  |
| Fracture   Laceration   Sprain/Strain   Head Injury   Dislocation   Skin Injury   Recurring Injury   Other (Specify)   Injury Type:   Contact   Non-Contact   Symptoms:   Loss of Feeling   Pain   Dizziness   Shortness of Breath   Loss of Consciousness/ Fainting*   Other (Specify)   *All loss of consciousness or fainting requires IMMEDIATE medical follow-up-CALL   First Aid/Care:   Trainer   Hospital   EMS   Family Dr.   Coach   Other (Specify)   Trainer   Hospital   EMS   Family Dr.   Coach   Other (Specify)   Injury and if it could have been avoided:   First Aid/Care:   Trainer   Hospital   EMS   Family Dr.   Coach   Other (Specify)   Injury transported by:   Ambulance   Private Vehicle   Driver:   Caregiver:   (If known)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   CPR   Stretching   Manual Therapy   Dressing   Was Injured Party filed an insurance calim   None   Was Injured Party filed an insurance calim   Yes   No   Name of Insurance Company:   SIGNATURE OF INJURED PARTY (PARENT OR LEGAL GUARDIAN):   SIGNATURE & NAME OF WITNESS:   SIGNATURE & SIGNATURE & NAME OF WITNESS:   SIGNATURE & NAME OF WITNESS:   SIGNATURE & SIGNATURE & SIGNATURE & SIGNATURE & SIGNATURE & SIGNA   | Your   |                      |   | · ·               | · · ·                        |  |
| Dislocation   Skin Injury   Recurring Injury   Other (Specify)   Other (Specify)   Injury Type:   Contact   Non-Contact   Symptoms:   Loss of Feeling   Pain   Dizziness   Shortness of Breath   Other (Specify)   *All loss of consciousness / Fainting*   Other (Specify)   *All loss of consciousness of fainting requires IMMEDIATE medical follow-up - CALL   First Aid/Care:   Trainer   Hospital   EMS   Family Dr.   Coach   Other (State below what caused the injury and if it could have been avoided:   First Aid/Care:   Trainer   Hospital   EMS   Family Dr.   Coach   Other (If treated at Hospital, party transported by:   Ambulance   Private Vehicle   Driver:   Caregiver:   (if known)   Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   CPR   Stretching   Manual Therapy   Dressing   Wrapping/ Taping   Sling/ Splint   None   Was injured Party wearing any protective equipment or other devices, shin guards, glasses, other personal equipment?   Yes   No   Name of Insurance Company:   SIGNATURE & NAME OF WITNESS:   Signature   Skin Injury   Contact   Spring   Skin Injury   Contact   Spring   Shint   Spring    | ) A A Side A Back  | 1 1                  | 1 11  |                   |                              |  |
| Injury Type:   |  | \ \ \                | • •   | ☐ Recurring I     | njury                        |  |
| Injury Type:   | wrist of   | Other (Sp            | ecity)  |                   |                              |  |
| Symptoms:   Loss of Feeling   Pain   Dizziness   Shortness of Breath   Loss of Consciousness/ Fainting*  | Hand &   |                      |   | □ Non Conto       |                              |  |
| Shortness of Breath   Cother (Specify)   |  |                      | Symptoms: □Loss of Feeling □ Pain □ Dizziness                           |                   |                              |  |
| *All loss of consciousness or fainting requires IMMEDIATE medical follow-up - CALL  Please circle and indicate the injured body part on the diagram above. State below what caused the injury and if it could have been avoided:    First Aid/Care:   Trainer   Hospital   EMS   Family Dr.   Coach   Other If treated at Hospital, party transported by:   Ambulance   Private Vehicle Driver:   Caregiver:   (if known) Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   CPR   Stretching   Manual Therapy   Dressing   Wrapping/ Taping   Sling/ Splint   None    Was Injured Party wearing any protective equipment or other devices, shin guards, glasses, other personal equipment?   Yes   No Please describe:   Has injured party filed an insurance claim   Yes   No Name of Insurance Company:   SIGNATURE & NAME OF WITNESS:   SIGNATURE & SIGNATURE & NAME OF WITNESS:   SIGNATURE & SIGNATURE & SIGNATURE | ( ) Knee ( )   | ☐ Shortnes           |   |                   |                              |  |
| *All loss of consciousness or fainting requires IMMEDIATE medical follow-up - CALL  Please circle and indicate the injured body part on the diagram above. State below what caused the injury and if it could have been avoided:    First Aid/Care:   Trainer   Hospital   EMS   Family Dr.   Coach   Other If treated at Hospital, party transported by:   Ambulance   Private Vehicle Driver:   Caregiver:   (if known)  | \0/  | ☐ Other (Sp          | ecify)  |                   |                              |  |
| If treated at Hospital, party transported by:   Ambulance   Private Vehicle  |  | *All loss of         | consciousness or fainting   | requires IMMEDIA  | ATE medical follow-up - CALL |  |
| Priver:  | • • • •  |                      | First Aid/Care: ☐ Trainer ☐ Hospital ☐ EMS ☐ Family Dr. ☐ Coach ☐ Other |                   |                              |  |
| Initial Treatment:   Rice (Rest, Immobilize, Cold, Elevate)   CPR   Stretching   Manual Therapy   Dressing   Wrapping/ Taping   Sling/ Splint   None   Was Injured Party wearing any protective equipment or other devices, shin guards, glasses, other personal equipment?   Yes   No Please describe:   Has injured party filed an insurance claim   Yes   No Name of Insurance Company:   SIGNATURE OF INJURED PARTY (PARENT OR LEGAL GUARDIAN):   SIGNATURE & NAME OF WITNESS:   SIGNATURE &    | State below what caused the injury and if it could have been avo   | II treated at        |   |                   |                              |  |
| Please indicate in the diagram where the injury occurred:  Was Injured Party wearing any protective equipment or other devices, shin guards, glasses, other personal equipment? Tyes No Please describe: Has injured party filed an insurance claim Yes No Name of Insurance Company: SIGNATURE OF INJURED PARTY (PARENT OR LEGAL GUARDIAN):  SIGNATURE & NAME OF WITNESS:   |  |                      |   |                   |                              |  |
| Please indicate in the diagram where the injury occurred:  Was Injured Party wearing any protective equipment or other devices, shin guards, glasses, other personal equipment?  Has injured party filed an insurance claim  Name of Insurance Company:  SIGNATURE OF INJURED PARTY (PARENT OR LEGAL GUARDIAN):  SIGNATURE & NAME OF WITNESS:  |  |                      | •   |                   | •                            |  |
| other personal equipment?     Yes   No   Please describe:   Has injured party filed an insurance claim   Yes   No   Name of Insurance Company:   SIGNATURE OF INJURED PARTY (PARENT OR LEGAL GUARDIAN):   SIGNATURE & NAME OF WITNESS:   |  | ☐ Wrapping           | g/Taping   Sling/   | Splint   No       | ne                           |  |
| Has injured party filed an insurance claim   | Please indicate in the diagram where the injury occ  |                      |   |                   |                              |  |
| SIGNATURE OF INJURED PARTY (PARENT OR LEGAL GUARDIAN):  SIGNATURE & NAME OF WITNESS:   |  |                      |   |                   |                              |  |
| SIGNATURE & NAME OF WITNESS:   |  |                      |   |                   |                              |  |
| Field # Field # D =  |  | SIGNATUR             | E OF INJURED PART   | Y (PARENT OR LEG. | AL GUARDIAN):                |  |
| Field # Field # D =  |  | SIGNATUR             | E & NAME OF WITN  | ME OF WITNESS:    |                              |  |
|  |  |                      |   |                   |                              |  |
| Date: (Day/ Month/ Year)   | 38   | Date:                | (Day/ Mon   | th/ Year)         |                              |  |