HEAD TRAUMA REPORT FORM

1. Date and Time

Time of Incident:		**Date of Incident:**	
Exact location:			

2. Personnel Involved

Full Name:		**Position:**			
Date of Birth:		**Sex:**		**Phone Number:**	
Employment details (player or other)					

3. Incident Details

TRAUMA THAT MAY HAVE RESULTED IN HEAD INJURY / CONCUSSION

i.) Participant struck in the head or neck (either bare or while wearing headgear) by the ball ☐ **Yes** ☐ No

ii.) Participant collided head or neck with another player, umpire or fixture ☐ **Yes** ☐ No

(If neither of these has occurred then the CA Concussion and Head Trauma Policy does **not** apply.)

If Headgear was worn at the time of trauma, please provide details (e.g. type, brand and model):

_____

REMOVAL FROM PLAY

Under the CA Concussion and Head Trauma Policy the injured person should be removed from play (a) with trauma (i. or ii.) above and (b) if concussion is suspected by the medical staff member and/or (c) if any of the following observations are made by any medical staff member, teammate or umpire:

Clear diagnosis of concussion requiring immediate removal and no return that day:

Loss of consciousness	☐ **Yes**	☐ No
No protective action in fall to ground directly observed or on video	☐ **Yes**	☐ No
Impact seizure or tonic posturing	☐ **Yes**	☐ No
Inability to keep balance (either on pitch or during subsequent testing)	☐ **Yes**	☐ No
Vomiting (not explained by other cause such as gastro)	☐ **Yes**	☐ No
Disorientation	☐ **Yes**	☐ No
Amnesia/memory disturbance	☐ **Yes**	☐ No
Behavioural change	☐ **Yes**	☐ No

Requires immediate removal from play for further assessment (SCAT-3, Cogsport or test approved by CA CMO):

Headache	☐ Yes	☐ No
Dizziness/nausea	☐ Yes	☐ No
Failure to resume normal posture/stance immediately after impact (stumbles or staggers)	☐ Yes	☐ No

4. Outcome

OUTCOME OF HEAD TRAUMA ASSESSMENT

Clear diagnosis of concussion removed with no return to play that day	☐ OUT
Removed from play and not permitted to return after objective assessment gave concussion diagnosis	☐ OUT
Removed from play but permitted to return after objective assessment did not result in concussion diagnosis	☐ OK
No criteria for removal	☐ OK

5. Response to Injury

Name of attending First-Aid Officer or Medical Personnel			
Treatment administered			
Did the person attend a doctor / hospital?		**Name, address & phone number of doctor & hospital:**	
Medical treatment administered			

6. Compliance with Concussion Policy Requirements

Did the injured/impacted person comply with the requirements of the Concussion and Head Trauma Policy?	
Please describe how such compliance / non-compliance occurred.	

7. Sign-off

Medical Officer	Date	Signature