



HEAD INJURY / SUSPECTED CONCUSSION REPORT

Complete this form immediately following the incident.

1 ATHLETE INFORMATION

Athlete Name: _____

Date of Birth: _____

Sport: _____

Team / Grade: _____

Coach / Staff Name: _____

Date: ____ / ____ / ____

Time of Injury: _____ ☐ AM ☐ PM

Location: ☐ Practice ☐ Game ☐ Other _____

2 DETAILS OF INCIDENT

Describe what happened (include how injury occurred, activity, and any impact):

3 SIGNS / SYMPTOMS OBSERVED Check all that apply.

- | | | |
|---|---|---|
| ☐ Headache | ☐ Nausea / Vomiting | ☐ Difficulty Concentrating |
| ☐ Dizziness | ☐ Appeared Dazed | ☐ Memory Problems |
| ☐ Confusion | ☐ Sensitivity to Light | ☐ Hit Head |
| ☐ Balance Problems | ☐ Sensitivity to Noise | ☐ Other: _____ |

4 ACTION TAKEN



Removed from
play immediately



Parent/Guardian
notified



Head Injury
Report completed



EMS called
(if applicable)

Time Parent/Guardian Notified: _____

Method: ☐ Phone ☐ Text ☐ In Person ☐ Email

Name of Person Contacted: _____

Notes: _____

6 EMS / MEDICAL INFORMATION (If EMS was called or athlete transported)

EMS Called: ☐ Yes ☐ No If Yes, Unit #: _____ Transported to Hospital: ☐ Yes ☐ No

Hospital / Facility: _____

Notes: _____

5 RETURN TO PLAY



THE ATHLETE DID NOT RETURN TO PLAY.

A written medical clearance from a
licensed healthcare provider is required
before the athlete may return to any
Brimfield Recreation practice, game,
or activity.

Coach / Staff Signature: _____

Date: ____ / ____ / ____



A COPY OF THIS COMPLETED
FORM MUST BE EMAILED TO:

- ☒ PARENT / GUARDIAN
- ☒ SPORT COORDINATOR

