[INSERT ORGANIZATION LOGO]

CONCUSSION INCIDENT FORM

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| --- |
| **INCIDENT REPORT FORM** |
| **Participant Information** | Date: |
| Last Name: | First Name: |
| Phone: | Email: |
| Gender Identity: Man | Woman |  | re | Prefer to Self-describe as |  Date of Birth: |
| Address: |
| Known medical conditions/allergies: |
| **INCIDENT INFORMATION REPORT** |
| Date of incident: |  |
| Time of first intervention: |  |
| Time of medical support: |  |
| Describe the incident (what took place, where it took place, what were the signs and symptoms of the injured person): |
| Event and Conditions (what was the event during which the incident took place, location of incident, conditions, weather, etc): |
| Actions Taken/Intervention: |
| After intervention, the individual was: |  Sent home |  Sent to hospital | Returned to activity |
| Form completed by: |  |
| Print |
|  |  |
| Date | Signature |

Information provided in this form will remain private and confidential.

COMPLETED FORMS MUST BE SUBMITTED TO [INSERT ORGANIZATION NAME]

**[INSERT** **ORGANIZATION EMAIL ADDRESS]**