Unionville Milliken Soccer Club
Concussion Incident Report

Date of incident: _____ Name of player/Team: _____

Type of event: Practice Game Tournament Location of event: _____

Summary of incident: _____

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Did the player demonstrate any signs or symptoms of concussion? (Check all that apply)

☐ Headache	☐ Light sensitivity	☐ Severe headache
☐ Fatigue	☐ Noise sensitivity	☐ Prolonged loss of consciousness (>30 min)
☐ Dizziness	☐ Forgetfulness	☐ Prolonged posttraumatic amnesia (>24 hrs)
☐ Balance problems	☐ Blurry vision	☐ Progressive worsening of symptoms
☐ Slowed mentation	☐ Sleep disturbance	☐ Impaired alertness
☐ Drowsiness	☐ Irritability	☐ Seizures
☐ Difficulty concentrating	☐ Depression/sadness	☐ Focal neurological deficits
☐ Nausea	☐ Vomiting	☐ Other: _____
	☐ Tinnitus (ringing ears)	

Were emergency medical services (911) called? Yes No

Did the player leave in an ambulance? Yes No

Was the player's parents present? Yes No

Did the player leave with their parent(s)? Yes No

Do you have any other notes/comments about the incident: _____

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Thank you for filling out this incident report. Please sign below to confirm that the information provided is as accurate as possible and there are no misrepresentations.

If player is not part of OPDL, please provide parent names and contact information.

Name (printed): _____ Signature: _____

Date: _____