

CLA Head Injury Incident Report

Please print and submit via e mail to info1@lacrosse.ca or fax to 613-260-2029 **within 30 days** of the incident - Provide copy to your Member Association Representative

SECTOR: Box Men's Field

LEVEL: _____ TEAM: _____ CLUB: _____

DATE & TIME OF INCIDENT: _____ LOCATION: (city, prov/state) _____

Injured Player Name: _____ Player DOB: _____

Describe incident in detail (use additional pages if necessary and attach photos):

Was any penalty called on the play that caused the injury? Yes No

If so, what was the penalty?

Did the player receive medical attention? Yes No

Did the player go to the hospital? Yes No

If so, describe diagnosis and treatment:

What is the make/model of the helmet worn? _____

What is the make/model of the facemask worn? _____

It is mandatory to include a photo of any visible injury, the helmet and facemask as it appeared when the incident occurred and, if possible, while being worn by the player.

To the best of your knowledge, was the equipment installed correctly? Yes No

Name of individual completing this form: _____ Signature: _____

Role (coach, parent, player, etc.) _____ Date: _____

Phone Number: _____ E Mail Address: _____

Witness to Incident: Role (coach, parent, player, etc.) _____

Name: _____ Signature: _____ Date: _____

Phone Number: _____ E Mail Address: _____