



**STRATFORD MINOR HOCKEY ASSOCIATION**

*Effective September 2017*

**RETURN TO PLAY**  
**CONCUSSIONS**

**(OR SUSPECTED CONCUSSIONS)**

*Please detach the following pages:*

**Trainers retains "Trainer Copy" page(s)**

**Player receives "Player Copy" page(s)**

**Both Trainer and Player should follow the  
instructions provided.**



# Return to Play Policy: CONCUSSIONS

To be followed when a player leaves the ice with concussion-like symptoms or is asked to return to the bench at the discretion of the Trainer following an on-ice incident that may have resulted in a possible concussion.

**A Note about Dr. Trish Van Boekel:** Players may make an appointment with Dr. Van Boekel without a referral; appointments are covered by OHIP. Dr. Van Boekel is a sports medicine doctor with concussion management experience. Her office is at the Stratford Rotary Complex.

## CALL 911 if player is unconscious, has decreased consciousness, has suspected neck or other life threatening injury.

- Trainer performs on-bench injury assessment (see **Concussion: On-Field Management**) (*attached*)
- If showing signs or symptoms of concussion, player returns to dressing room with assistance.
- Trainer completes a **Hockey Canada Injury Report** (*attached*). If during a game, retain a copy of the Game Sheet or take a cell phone photo of the game sheet to print later.
- Trainer should, before player leaves the rink if possible, provide the player (or parent) with the following documents (*all attached*):
  - Return to Play Policy: Concussions** (*This page, please follow steps listed*)
  - Hockey Canada Injury Report** (*2 Pages, Must be completed by Trainer, physician and parent*)
  - Return to Play: Permission Form** (*1 Page, Must be completed by physician*)
  - Return to Play Protocol** (*1 Page Recommended Protocol*)
  - Sport Concussion** (*2 Page Educational Handout*)
- Player sees physician for treatment and health care; player should follow physician's instructions.
- Player should have the physician complete both the **Return to Play: Permission Form** and the "Physician's Statement" on the **Hockey Canada Injury Report**.

## IF CONCUSSION FREE:

***If, after visiting physician, no concussion is suspected, player may return to play once the following are complete:***

- Player has returned the completed **Return to Play: Permission Form** to the Trainer.
- Player has returned the completed **Hockey Canada Injury Report** to the Trainer
- Trainer submits the **Return to Play: Permission Form** to the SMHA Secretary.
- Trainer submits **Hockey Canada Injury Report** with Game Sheet to the SMHA Secretary.

## SUSPECTED CONCUSSION or CONCUSSION DIAGNOSIS:

- Trainer notifies SMHA Secretary.
- Player follows treatment plan as directed by their physician, obtaining signatures on the **Return to Play: Permission Form** in SECTION 2 as rehabilitation takes place. The recommended **Return to Play Protocol** (*attached*) is for physician and parent reference as needed.

***Any time required for the player to be reintroduced onto the ice in steps must be coordinated through the Head Coach or Manager. Parents are not permitted to contact other teams in the hopes of using their ice. When the player has received final physician clearance to return to play without restriction, player may return to play once the following are complete:***

- Player has returned the completed **Return to Play: Permission Form** to the Trainer.
- Parents have completed the "Health Insurance Information" section of the **Hockey Canada Injury Report** and returned the completed report to the Trainer.
- Trainer submits the **Return to Play: Permission Form** to the SMHA Secretary.
- Trainer submits **Hockey Canada Injury Report**, Game Sheet and any other relevant paperwork to the SMHA Secretary.
- Trainer notifies the SMHA Secretary that the player has returned to play.

*Trainers, please refer to "Duties of a Team Trainer" for additional details.*

# Return to Play Policy: CONCUSSIONS

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COPY

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*Trainers, please refer to "Duties of a Team Trainer" for additional details.*



See reverse for mailing address

# HOCKEY CANADA INJURY REPORT



CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF THE INJURY DATE: \_\_\_/\_\_\_/\_\_\_  
Mo. Day Yr.

INJURED PARTICIPANT:  Player  Team Official  Game Official  Spectator  
Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Sex: (M) (F)  
Mo. Day Yr.

Address: \_\_\_\_\_ City / Town: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_

**DIVISION:**

- Initiation  Novice  Atom  PeeWee
- Bantam  Midget  Juvenile

**CATEGORY:**

- AAA  AA  A  B  BB  C  CC
- D  DD  E  House  Major Junior  Minor Junior
- Senior  Adult Rec  Other

**BODY PART INJURED: \* visit the Hockey Canada web-site for an optional questionnaire \***

- |                                                                 |                                                                 |                                                                        |                                                             |                                |                                                                 |                                                               |                                                                          |                                                              |                                |
|-----------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------|--------------------------------|
| <b>Head</b>                                                     | <b>Back</b>                                                     | <b>Trunk</b>                                                           | <b>Arm</b>                                                  | <input type="checkbox"/> Left  | <input type="checkbox"/> Right                                  | <b>Pelvis</b>                                                 | <b>Leg</b>                                                               | <input type="checkbox"/> Left                                | <input type="checkbox"/> Right |
| <input type="checkbox"/> Eye Area <input type="checkbox"/> Face | <input type="checkbox"/> Neck <input type="checkbox"/> Ribs     | <input type="checkbox"/> Shoulder <input type="checkbox"/> Hand/Finger | <input type="checkbox"/> Hip <input type="checkbox"/> Thigh | <input type="checkbox"/> Foot  | <input type="checkbox"/> Throat <input type="checkbox"/> Dental | <input type="checkbox"/> Upper <input type="checkbox"/> Chest | <input type="checkbox"/> Upperarm <input type="checkbox"/> Forearm/Wrist | <input type="checkbox"/> Groin <input type="checkbox"/> Knee | <input type="checkbox"/> Toe   |
| <input type="checkbox"/> Skull                                  | <input type="checkbox"/> Lower <input type="checkbox"/> Abdomen | <input type="checkbox"/> Elbow <input type="checkbox"/> Collarbone     | <input type="checkbox"/> Shin                               | <input type="checkbox"/> Other |                                                                 |                                                               |                                                                          |                                                              |                                |

**NATURE OF CONDITION:**

- Concussion  Laceration  Fracture  Sprain  Strain
- Contusion  Dislocation  Separation  Internal Organ Injury

**ON-SITE CARE:**  On-Site Care Only  Refused Care

- Sent to Hospital by:  Ambulance  Car

**INJURY CONDITIONS: Name of arena / location:** \_\_\_\_\_

- Exhibition / Regular Season**  **Playoffs / Tournament**  **Practice**  **Try-outs**  **Other**
- Warm-up  Period #1  Period #2  Period #3  Overtime # \_\_\_\_\_
- Dry Land Training  Gradual Onset  Other Sport  Other: \_\_\_\_\_

Was the injured player in the correct league and level for their age group?  Yes  No

Was this a sanctioned Hockey Canada activity?  Yes  No

**CAUSE OF INJURY:**

- Hit by Puck  Collision with Boards  Non-Contact Injury
- Hit by Stick  Collision on Open Ice  Collision with Opponent
- Fall on Ice  Checked From Behind  Collision with Net
- Fight  Blindsiding

**LOCATION:**

- Defensive Zone  Offensive Zone  Neutral Zone
- Behind the Net  3 ft. from Boards  Spectator Area
- Parking Lot  Dressing Room  Bench
- Other: \_\_\_\_\_

**WEARING WHEN INJURED:**

- Full Face Mask  Intra-Oral Mouth Guard
- Half Face Shield/Visor  Throat Protector
- Helmet/No Face Shield  No Helmet/No Face Shield
- Short Gloves  Long Gloves

**ADDITIONAL INFORMATION:**

- Has the player sustained this injury before?  Yes  No  
If "Yes" how long ago \_\_\_\_\_
- Was a penalty called as a result of the incident?  Yes  No
- Estimated Absence from hockey?  1 week  1-3 weeks  3+ weeks

**DESCRIBE HOW ACCIDENT HAPPENED:**  
(Attach page if necessary)

I hereby authorize any Health Care Facility, Physician, Dentist or other person who has attended or examined me/my child, to furnish Hockey Canada any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all dental, hospital, and medical records. A photostatic/electronic copy of this authorization shall be considered as effective and valid as the original.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Guardian if under 18 years of age)

**TEAM INFORMATION:** (To be completed by a Team Official)

Association: \_\_\_\_\_ Team Name: \_\_\_\_\_  
 Team Official (Print) \_\_\_\_\_ Team Official Position: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HEALTH INSURANCE INFORMATION:**

**THIS MUST BE FILLED OUT IN FULL OR FORM PROCESSING WILL BE DELAYED**

Occupation:  Employed Full-time  Employed Part-time  Unemployed  Full-Time Student  
Employer (If minor, list parent's employer): \_\_\_\_\_

- Do you have provincial health coverage?  Yes  No Province: \_\_\_\_\_
- Do you have other insurance?  Yes  No (IF "YES", PLEASE SUBMIT CLAIM TO YOUR PRIMARY HEALTH INSURER.)
- Has a claim been submitted?  Yes  No (IF "YES", PLEASE FORWARD PRIMARY INSURER EXPLANATIONS OF BENEFITS.)

Make Claim Payable To:  Injured Person  Parent  Team  Other: \_\_\_\_\_

**Branch APPROVAL**

**PHYSICIAN'S STATEMENT**

Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_

Name of Hospital / Clinic: \_\_\_\_\_ Address: \_\_\_\_\_

Nature of Injury: \_\_\_\_\_ Date of First Attendance: \_\_\_\_\_

\_\_\_\_\_ Claimant will be totally disabled:  
From: \_\_\_\_\_ To: \_\_\_\_\_

Is the injury permanent and irrecoverable?  No  Yes

Give the details of injury (degree): \_\_\_\_\_

Prognosis for recovery: \_\_\_\_\_

Did any disease or previous injury contribute to the current injury?  No  Yes (describe): \_\_\_\_\_

Was the claimant hospitalized?  No  Yes (give hospital name, address and date admitted): \_\_\_\_\_

Names and addresses of other physicians or surgeons, if any, who attended claimant: \_\_\_\_\_

I certify that the above information is correct and the best of my knowledge,

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**DENTIST STATEMENT**

Limits of coverage: \$1,000 per tooth, \$2,000 per accident  
Treatment must be completed within 52 weeks of accident

P LAST NAME GIVEN NAME		UNIQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM DIRECTLY TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM / HER
A			
T		D E N T I S T	SIGNATURE OF SUBSCRIBER _____
I ADDRESS APT.			
E		PHONE NO.	
N			
T CITY PROV. POSTAL CODE			

FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIANOGNIS OR SPECIAL CONSIDERATION.

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT.  
I ACKNOWLEDGE THAT THE TOTAL FEE OF \$ \_\_\_\_\_ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR THE SERVICES RENDERED.  
I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

DUPLICATE FORM

\_\_\_\_\_  
SIGNATURE OF (PATIENT/GUARDIAN)

**OFFICE VERIFICATION**

DATE OF SERVICE DAY / MO. / YR.	PROCEDURE	INITIAL TOOTH CHARGE	TOOTH SURFACE	DENTIST'S FEE	LAB CHARGE	TOTAL CHARGE

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE & OE.

**TOTAL FEE SUBMITTED**

NOTE: All benefits subject to insurer payor status, provisions of the policy, Hockey Canada sanctioned events.

**Mail completed form to:**  
**ALLIANCE Hockey**  
**71 Albert Street Stratford, ON N5A 3K2**  
**Tel : 519-273-7209 Fax : 519-273-2114**



# Return to Play PERMISSION FORM

PLAYER  
COPY

This form is to be given to any player after ANY injury in which a concussion is suspected.

Dear Physician:

Thank you for seeing our athlete. Your assessment is critical to safe recovery of our players. SMHA has adopted a Return to Play policy for any athlete suspected of having a concussion. Per our guidelines, a physician is required to authorize that the athlete meets necessary medical criteria for consideration to either return to regular play or to proceed with more supervised management. Please complete SECTION 1 below. SECTION 2 only gets completed if the athlete has sustained a concussion.

## SECTION 1

After your assessment, please check one of the following boxes:

- After assessment, it is my impression that medically the player is able to return to play without restriction.
- After assessment, it is my impression that the player is not able to return to play and requires further supervised management prior to return to play. Section 2 should be completed as athlete rehabilitates.

Name of Physician: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

## SECTION 2

<i>Health Care Provider</i>	
<b>1. FOLLOW UP ASSESSMENT &amp; PLAN OF CARE</b> <input type="checkbox"/> Athlete has had follow-up assessment/testing with a registered Health Care Provider trained in concussion management. An individualized rehabilitation plan has been recommended/ implemented to support recovery.	<i>Name:</i>
	<i>Signature:</i>
	<i>Date Completed:</i>
<b>2. REHABILITATION PLAN COMPLETE</b> <input type="checkbox"/> Athlete has satisfied all necessary clinical rehabilitation requirements and is discharged to Physician for further return-to-play recommendations ( <i>refer to recommended Return to Play Protocol</i> ).	<i>Name:</i>
	<i>Signature:</i>
	<i>Date Completed:</i>
<b>3. FINAL PHYSICIAN CLEARANCE</b> <input type="checkbox"/> After final assessment, it is my impression that medically the athlete is able to return to play without restriction.	<i>Name:</i>
	<i>Signature:</i>
	<i>Date Completed:</i>
<b>4. FORM SUBMISSION TO SMHA</b> <input type="checkbox"/> Athlete has returned completed Permission Form and Hockey Canada Injury Report to Team Trainer.	<i>Date Submitted:</i>

Dr. Patricia Van Boekel, MD, CCFP-EM, SEM  
 Stratford Rotary Complex  
 Room 136- 353 McCarthy Road  
 Stratford Ontario, N5A 7S7  
 Phone: 519-271-3030 Fax: 519-271-3038

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## Return to Play Protocol

NO athlete with suspected concussion should be allowed to return to play on the same day as the injury, no matter what the level of play. Proper identification and early management will increase the chance of successful recovery.

Once acute symptoms have improved and the athlete has been medically cleared by a physician, he or she may begin a stepwise progression of activity as outlined below. Each step should take 24 hours, but if any symptoms return, the athlete should drop back to the previous level and try to progress again after a 24 hour period of rest.

For the younger athlete, it is recommended to follow a more prolonged return to play protocol with 48 hours per step. As well, it is suggested that a student athlete needs to return to school successfully before trying to engage in returning to their sport.

### RETURN TO PLAY PROTOCOL:

**For all steps: If you experience symptoms, return to rest until symptoms have resolved for 24 hours and then restart at the previous level. If symptoms persist, consult a physician.**

**If you do not experience any increase in symptoms or signs during the activity or for 24-48 hours following, you may proceed to the next step.**

#### Step 1

No Activity (stay at this step until you are symptom free at rest).

#### Step 2

Light Aerobic Exercise (Walking, swimming, or stationary cycling - maximum intensity of <70%).

No resistance training or weight lifting.

Supervised by someone who can monitor for signs and symptoms.

Gradual increase in duration/intensity of aerobic exercise if no signs or symptoms in 24 hours.

#### Step 3

Sport Specific Exercise (Skating drills in hockey, running drills in soccer. No head impact/jarring activities such as high speed stops or hitting a baseball).

#### Step 4

Non-contact Training Drills (Progression to more complex training drills – eg, passing drills. May start progressive resistance training).

Medical clearance by a medical professional should be obtained before progressing to Step 5 and 6.

#### Step 5

Full Contact Practice (Participate in normal training activities)

#### Step 6

Return to Play (Normal game play)





## SPORT CONCUSSION

### 1. What is a Concussion?

A concussion is a form of a mild traumatic brain injury that causes a change in brain function. A concussion can occur with or without a direct blow to the head. Concussion does not have to result in a loss of consciousness. It is important to recognize a concussion when it first occurs. Proper management from the outset can help prevent further injury and even death. When managed appropriately, the majority of sport concussions resolve in a short time. However, the amount of time varies from person to person and can be prolonged for some people.

### 2. What are the Signs and Symptoms of a Concussion?

Concussion symptoms differ with each person and with each injury. They may begin immediately or may not be noticeable for hours or days. It is important to STOP activity if you suspect you have a concussion and DO NOT return to play for the rest of the day.

Signs and symptoms may evolve minutes to hours after the injury and may include:

PHYSICAL	EMOTIONAL	COGNITIVE
<ul style="list-style-type: none"><li>• Headaches</li><li>• Nausea/Vomiting</li><li>• Dizziness</li><li>• Light/noise sensitivity</li><li>• Lightheadedness</li><li>• Balance problems</li><li>• Blurred/double vision</li><li>• Neck pain</li><li>• Ringing in the ears</li></ul>	<ul style="list-style-type: none"><li>• Irritability</li><li>• Depression</li><li>• Sadness</li><li>• More emotional</li><li>• Anxiety</li><li>• Moodiness</li></ul>	<ul style="list-style-type: none"><li>• Trouble concentrating/remembering</li><li>• Fogginess</li><li>• Trouble falling asleep</li><li>• Sleeping too much</li><li>• Decreased energy</li><li>• Fatigue</li><li>• Don't feel right</li><li>• Drowsiness/confusion</li><li>• Slow reaction time</li></ul>

**If you develop any of the following symptoms, go to the nearest Emergency Department.**

<ul style="list-style-type: none"><li>• Severe/worsening headache</li><li>• Vomiting</li><li>• Unusual behaviour</li><li>• Seizures</li><li>• Neck pain/tenderness</li><li>• Numbness/Weakness in arms/legs</li><li>• Fluid/blood leaking from the nose or ears</li></ul>	<ul style="list-style-type: none"><li>• Decreased balance/coordination</li><li>• Decreasing level of consciousness</li><li>• Disorientation/confusion</li><li>• Unequal pupils</li><li>• Irritability</li><li>• Slurred speech</li><li>• Double or blurry vision</li></ul>
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## Dr. Patricia Van Boekel, MD, CCFP-EM, SEM

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### **3. I was diagnosed “on the field” as having a Concussion, what do I do now?**

DO NOT ignore your symptoms - ignoring your symptoms and trying to “tough it out” often makes symptoms worse. Tell your coach, parent, and trainer if you think you or one of your teammates may have a concussion. Don’t let anyone pressure you into continuing to practice or play with a concussion. It is important that you DO NOT return to the playing field.

You should be assessed on site by a trainer with concussion training, but if this is not available, you should see a doctor as soon as possible for evaluation.

If you have been cleared to go home, there should be an adult to observe you to watch for any deterioration as this could indicate a more severe injury. You should see your family doctor as soon as possible.

With a diagnosis of concussion a 24-48 hour period of complete mental and physical rest is recommended. This means no TV, video games, texting, and schoolwork, along with avoiding physical activity. It is advised that you do not drive a motor vehicle until cleared to do so by a medical professional.

## **For More Information on Concussion**

### **Please Visit**

[www.parachutecanada.org](http://www.parachutecanada.org)

[www.onf.org](http://www.onf.org)

Video for hockey: youtube – SMART HOCKEY 12 ON-ICE HOCKEY TIPS

APP: ConcussionEd by Parachute

APP: Concussion Awareness – Hockey Canada