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.

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Sport Medicine Physician
Stratford Rotary Complex
Room 136- 353 McCarthy Road
Stratford, Ontario N5A 7S7
Phone: 519-271-3030
Fax: 519-271-3038

CONCUSSION: ON-FIELD MANAGEMENT

STEP 1

-Athlete unconscious or decreased consciousness?	**Call 911**
-Neck injury suspected	**Call 911**

STEP 2

Remove from play. If any of the following are present then **SEND TO EMERGENCY DEPARTMENT.**

-Vomiting	-Decreased balance/coordination
-Severe/worsening headache	-Decreasing level of consciousness
-Unusual behaviour	-Disorientation/confusion
-Seizures	-Unequal pupils
-Neck pain/tenderness	-Irritability
-Numbness/weakness in arms/legs	-Slurred speech

STEP 3

Remove from play. If any of the following symptoms, then check for concussion symptoms below.

Signs and Symptoms of Concussion

-Headache	-Irritability	-Trouble concentrating/remembering *
-Nausea/vomiting	-Depression	-Fogginess
-Dizziness	-Sadness	-Trouble falling asleep
-Light/noise sensitivity	-More emotional	-Decreased energy
-Balance problems	-Anxiety	-Fatigue
-Blurred/double vision	-Moodiness	-Feeling “off”
-Neck pain		-Drowsiness/confusion

*** Failure to answer any of these questions correctly may suggest a concussion:**
“What sporting event are we at today?”
“Which half/period is it now?”
“Who scored last in this game?”
“Which team did you play last game?”
“Did you team win the last game?”

NEXT STEPS

-DO NOT allow return to play on same day
-Athlete must be in care of responsible adult, provide concussion handout to player/parents
-Complete rest
-Follow up with family doctor, even if symptoms resolve
-If in doubt… sit them out

TRAINER COPY

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)*
  - ☐ **Sport Concussion FAQs** *(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.

PLAYER COPY

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

HOCKEY CANADA INJURY REPORT

See reverse for mailing address

Forms must be filled out in full or form will be returned. This form must be completed for each case where an injury is sustained by a player, spectator or any other person at a sanctioned hockey activity

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

INJURED PARTICIPANT: ☐ Player ☐ Team Official ☐ Game Official ☐ Spectator

Name: ______________________________ Birthdate: ____/____/____ Mo. Day Yr. Sex: (M) (F)

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 *

Head		**Back**	**Trunk**	**Arm** ☐ Left	☐ Right	**Pelvis**	**Leg** ☐ Left	☐ Right
☐ Eye Area	☐ Face	☐ Neck	☐ Ribs	☐ Shoulder	☐ Hand/Finger	☐ Hip	☐ Thigh	☐ Foot
☐ Throat	☐ Dental	☐ Upper	☐ Chest	☐ Upperarm	☐ Forearm/Wrist	☐ Groin	☐ Knee	☐ Toe
☐ Skull		☐ Lower	☐ Abdomen	☐ Elbow	☐ Collarbone		☐ Shin	☐ 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): ____

1. Do you have provincial health coverage? ☐ Yes ☐ No Province: ______________________
2. Do you have other insurance? ☐ Yes ☐ No (IF "YES", PLEASE SUBMIT CLAIM TO YOUR PRIMARY HEALTH INSURER.)
3. 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

PATIENT
LAST NAME GIVEN NAME
____
ADDRESS APT.
____
CITY PROV. POSTAL CODE

UNIQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO.

DENTIST
PHONE NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM DIRECTLY TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM / HER

____
SIGNATURE OF SUBSCRIBER

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

DUPLICATE FORM ☐

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 ACKNOWLEGDE 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.

____
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.

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

TOTAL FEE SUBMITTED

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

	Health Care Provider
1. FOLLOW UP ASSESSMENT & PLAN OF CARE ☐ 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.	***Name:*** ***Signature:*** ***Date Completed:***
2. REHABILITATION PLAN COMPLETE ☐ Athlete has satisfied all necessary clinical rehabilitation requirements and is discharged to Physician for further return-to-play recommendations *(refer to recommended Return to Play Protocol).*	***Name:*** ***Signature:*** ***Date Completed:***
3. FINAL PHYSICIAN CLEARANCE ☐ After final assessment, it is my impression that medically the athlete is able to return to play without restriction.	***Name:*** ***Signature:*** ***Date Completed:***
4. FORM SUBMISSION TO SMHA ☐ Athlete has returned completed Permission Form and Hockey Canada Injury Report to Team Trainer.	***Date Submitted:***

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SPORT CONCUSSION

WHAT IS A CONCUSSION?
A concussion is a brain injury that causes a change in brain function. A concussion can occur with or without a direct blow to the head and does not have to result in a loss of consciousness. It is important to recognize a concussion when it first occurs. Proper management from time of injury can help prevent further injury and even death.

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.

PHYSICAL	EMOTIONAL	COGNITIVE
• Headaches • Nausea/Vomiting • Dizziness • Light/noise sensitivity • Lightheadedness • Balance problems • Blurred/double vision • Neck pain • Ringing in the ears	• Irritability • Depression • Sadness • More emotional • Anxiety • Moodiness	• Trouble concentrating/remembering • Fogginess • Trouble falling asleep • Sleeping too much • Decreased energy • Fatigue • Don't feel right • Drowsiness/confusion • Slow reaction time/not playing as well

IF YOU DEVELOP ANY OF THE FOLLOWING SYMPTOMS, GO TO THE NEAREST EMERGENCY DEPARTMENT.

• Severe/worsening headache • Vomiting • Unusual behaviour • Seizures • Neck pain/tenderness • Numbness/Weakness in arms/legs • Fluid/blood leaking from the nose or ears	• Decreased balance/coordination • Decreasing level of consciousness • Disorientation/confusion • Unequal pupils • Irritability • Slurred speech • Double or blurry vision

WHAT SHOULD YOU DO IF YOU GET A CONCUSSION?
You should stop playing the sport right away. Continuing to play increases your risk of more severe, longer lasting concussion symptoms, as well as increases your risk of other injury. You should tell your coach, trainer, parent or other responsible person that you are concerned you have had a concussion, and should not return to play that day. You should not be left alone and should be seen by a doctor as soon as possible that day. You should not drive.

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PLAYER COPY

HOW IS A CONCUSSION TREATED?
The general recommendation is a brief 24-48 hour period of rest followed by a gradual return to light physical and cognitive activities as tolerated by the individual. It is important to remember to not push too hard, and only indulge in those activities that do not worsen the symptoms while progressing through the stages of recovery.

You should not exercise or do any activities that may make you worse, like driving a car, reading, working on the computer or playing video games. No snow shovelling, cutting the lawn, moving heavy objects, etc. If the mental activities (eg: reading, concentrating, using the computer) worsen your symptoms, you may have to stay home from school. If you go back to activities before you are completely better, you are more likely to get worse, and to have symptoms last longer.

HOW LONG WILL IT TAKE TO GET BETTER?
The signs and symptoms of a concussion often last for 10-14 days but may last much longer. In some cases, athletes may take many weeks or months to heal.

RETURN TO SCHOOL
Return to school should not happen until you feel better, and mental activities do not aggravate your symptoms. It is best to return to school part-time at first, moving to full time if you have no problems. Once you are completely better at rest, you can start a step-wise increase in activities. It is important that you are seen by a doctor before you begin the steps needed to return to activity, to make sure you are completely better.

WHEN CAN I RETURN TO SPORT?
It is very important that you do not go back to sports if you have any concussion symptoms or signs. Return to sport and activity must follow a step-wise approach:

STEP 1: After an initial short period of rest of 24-48 hours, light cognitive and physical activity can be initiated as long as they don't worsen symptoms. A physician should be consulted before beginning a step-wise return to learn and sport strategy.
STEP 2: Light exercise such as walking or stationary cycling, for 10-15 minutes.
STEP 3: Sport specific aerobic activity (ie. skating in hockey, running in soccer), for 20-30 minutes. NO CONTACT.
STEP 4: "On field" practice such as ball drills, shooting drills, and other activities with NO CONTACT (ie. no checking, no heading the ball, etc.).
STEP 5: "On field" practice with body contact, once cleared by a doctor.
STEP 6: Game play.

There should be at least 24 hours (or longer) for each step of the progression. If any symptoms worsen during exercise, you should go back to the previous step. Resistance training should be added only in the later stages (step 4 or 5 at the earliest.)

Resources:
www.parachutecanada.org