STRATFORD MINOR HOCKEY ASSOCIATION

Effective September 2017

RETURN TO PLAY

INJURIES

(OTHER THAN CONCUSSIONS)

Please detach the following pages:

Trainer retains "Trainer Copy" page(s)
Player receives "Player Copy" page(s)

Both Trainer and Player should follow the instructions provided.

Return to Play Policy:
INJURIES *(other than Concussions)*

TRAINER COPY

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

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- ☐ Trainer performs on-bench injury assessment.

↓

- ☐ If injured, player should return to dressing room with assistance.

↓

- ☐ Trainer should complete a **Hockey Canada Injury Report** (if during a game, retain a copy of the Game Sheet or take a cell phone photo of the game sheet to print later). The report should be given to the player.

↓

- ☐ Player sees physician for treatment and health care. Physician must complete "Physician's Statement" (if dental injury, dentist must complete "Dentist Statement") of the **Hockey Canada Injury Report**.

↓

- ☐ If, after visiting their physician, there is no injury, player may return the completed **Hockey Canada Injury Report** to the Trainer and may return to the team.

↓

- ☐ Trainer submits completed **Hockey Canada Injury Report** with Game Sheet to the SMHA Secretary.

IF PLAYER IS INJURED

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- ☐ If a major injury, Trainer notifies SMHA Secretary.

↓

- ☐ Player follows treatment plan as recommended by physician.

↓

When the player has been cleared to play by their physician:

- ☐ Player must provide the Trainer with a **Clearance Letter** from the physician.
- ☐ Player submits the completed **Hockey Canada Injury Report** to the Trainer (Physician must have completed the "Physician's Statement" and parents must have completed the "Health Insurance Information". (*)
- ☐ Trainer submits **Clearance Letter** to the SMHA Secretary.
- ☐ Trainer submits **Hockey Canada Injury Report**, Game Sheet and any other relevant paperwork to the SMHA Secretary.

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

(*) Hockey Canada is a secondary insurer; expenses must first be submitted to the player's primary insurer. If not covered by primary insurer, please attach (a) receipts, and (b) primary insurer claim rejection letter to the report in order to seek coverage from Hockey Canada.

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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

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: ____/____/____ 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

Branch APPROVAL

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: ____________________

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