# Athlete Concussion Medical Report Form

This form serves as an aid to medical professionals to inform an athlete's team staff regarding the diagnosis of concussion following an impact during a ringette activity. The form must be completed by a qualified physician.

| **STEP 1:** Release for Disclosing Personal Health Information (see over)<br>**MUST** be completed by athlete/parent/guardian prior to physician assessment | |
|---|---|
| **STEP 2:** Physician Athlete Assessment | |
| 1. Does the athlete have a concussion now? | YES ☐ NO ☐ |
| 2. Did the athlete suffer a concussion and symptoms are now resolved? | YES ☐ NO ☐ |

| Answers | | Action Items |
|---|---|---|
| 1. YES | 2. NO | Follow advice of Physician for immediate management steps and Concussion Return-to-play guidelines |
| 1. NO | 2. YES | Follow Concussion Return-to-play guidelines |
| 1. NO | 2. NO | May return to full ringette activities immediately |

**Consent to Disclose Personal Health Information**

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I,_____, authorize_____

*(Print your name)* *(Print name of health information custodian )*

to disclose:

**my personal health information consisting of the information provided regarding my injury as requested in the "Athlete Concussion Medical Report Form".**

or

□ **the personal health information of** _____

*(Name of person for whom you are the substitute decision-maker*)*

**consisting of the information provided regarding the injury as requested in the "Athlete Concussion Medical Report Form".**

to _____

*(Print name of the Head Coach/Trainer and Ringette Association requiring the information)*

**I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.**

**My Name:**_____**Address:**_____

Home Telephone or Mobile Telephone:_____

**Signature:**_____**Date:**_____

**Witness Name:**_____**Address:**_____

Home Telephone or Mobile Telephone:_____

**Signature:**_____**Date:**_____

***Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**