

## UTM Concussion Removal-from-Sport Form

Athlete Name: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_

If an athlete is suspected of sustaining a concussion either by sustaining a significant impact to the head, face, neck, or body and demonstrates any of the visual signs of a suspected concussion or reports any symptoms of a suspected concussion as detailed in this document they will be removed from play, regardless of whether or not the concussion was sustained from a sport activity associated with the University of Toronto Mississauga.

Please indicate which of the following Signs & Symptoms were exhibited by the Athlete:

Physical:	Headache	Sleep:	Sleeping more or less than usual
	Pressure in the head		Having a hard time falling asleep
	Dizziness	Cognitive:	Not thinking clearly
	Nausea or vomiting		Slower thinking
	Blurred vision		Feeling confused
	Sensitivity to light or sound		Problems concentrating
	Ringing in the ears		Problems remembering
	Balance problems	Emotional:	Irritability
	Tired or low energy		Depression
	Drowsiness		Sadness
	"Don't feel right"		Nervous or anxious

<p>"Red Flags" may mean the person has a more serious injury.          Treat "Red Flags" as an emergency and activate UTM's or Facility Emergency Action Plan.          Please indicate which of the following "Red Flags" were exhibited by the Athlete:</p>	
Neck pain or tenderness	Loss of consciousness (knocked out)
Double vision	Vomiting more than once
Weakness or tingling in arms or legs	Increasingly restless, agitated or aggressive
Severe or increasing headache	Getting more and more confused
Seizure or convulsion	

Please describe the events leading to the Removal-from-Sport:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Designated Person Name: \_\_\_\_\_

Designated Person Signature: \_\_\_\_\_

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