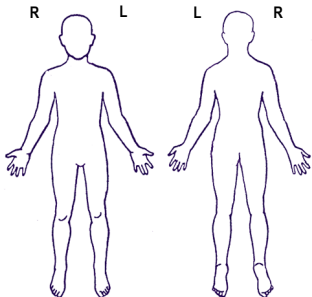


PLAYER INFORMATION

PLAYERS NAME	SURNAME	GIVEN NAME	MIDDLE NAME OR INITIAL
ADDRESS			
CITY	POSTAL CODE		
HOME PHONE	()	
PLAYER EMAIL	@		

INJURED BODY PART

	<p>SPECIFIC BODY PART</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>FOLLOW UP</p> <p><input type="checkbox"/> HOSPITAL</p> <p><input type="checkbox"/> FAMILY PHYSICIAN</p> <p><input type="checkbox"/> OTHER _____</p>	<p>FIRST AID TREATMENT</p> <p><input type="checkbox"/> ICE <input type="checkbox"/> TAPE <input type="checkbox"/> TENSOR</p> <p><input type="checkbox"/> SPLINT <input type="checkbox"/> CRUTCHES</p> <p><input type="checkbox"/> OTHER _____</p>													
		<p>VITAL SIGNS N/A <input type="checkbox"/></p> <table border="1"> <thead> <tr> <th>TIME</th> <th>PULSE</th> <th>B.P.</th> <th>RESP. RATE</th> <th>TEMP</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>		TIME	PULSE	B.P.	RESP. RATE	TEMP								
TIME	PULSE	B.P.	RESP. RATE	TEMP												

TYPE OF INJURY

<input type="checkbox"/> CONCUSSION WITH LOSS OF CONSCIOUSNESS	<input type="checkbox"/> RUPTURE OF TENDON	<input type="checkbox"/> CONTUSION
<input type="checkbox"/> CONCUSSION WITHOUT LOSS OF CONSCIOUSNESS	<input type="checkbox"/> LIGAMENT RUPTURE WITH INSTABILITY	<input type="checkbox"/> TENDONITIS / BURSITIS
<input type="checkbox"/> FRACTURE	<input type="checkbox"/> LIGAMENT RUPTURE WITHOUT INSTABILITY	<input type="checkbox"/> DENTAL INJURY
<input type="checkbox"/> DISLOCATION	<input type="checkbox"/> LESION OF MENISCUS	<input type="checkbox"/> DEEP WOUND
<input type="checkbox"/> RUPTURE OF MUSCLE	<input type="checkbox"/> SPRAIN	<input type="checkbox"/> LACERATION / ABRASION
<input type="checkbox"/> RUPTURE OF TENDON	<input type="checkbox"/> STRAIN	<input type="checkbox"/> OTHER _____

HISTORY / MECHANISM

<p>HAS THE PLAYER HAD A PREVIOUS INJURY OF THE SAME LOCATION AND TYPE?</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES _____ MONTHS AGO</p>	<p>WHEN DID THE INJURY OCCUR?</p> <p><input type="checkbox"/> TRAINING</p> <p><input type="checkbox"/> MATCH</p> <p>FIELD CONDITIONS _____</p>
<p>WAS THE INJURY CAUSED BY OVERUSE OR TRAUMA?</p> <p><input type="checkbox"/> OVERUSE</p> <p><input type="checkbox"/> TRAUMA</p>	<p>WAS THE INJURY CAUSED BY CONTACT WITH ANOTHER PLAYER?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p>

NOTES

<p>TRAINER NAME</p> <p>></p> <p>TEAM NAME</p> <p>></p> <p>HEAD COACH NAME</p> <p>></p>	<p>RETURN TO ACTIVITY TIME-LINE / HOME INSTRUCTIONS</p> <p>></p>
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