



Concussion Report Form

To be completed within 12 hours of incident/accident

Incident Date: _____ Incident Time: _____
Injured Person Name: _____
Address: _____
Phone Numbers: _____ Email _____
Male/Female: _____ Date of Birth: _____

Details of Incident:

Who was injured person? _____
Injury Type: _____

Does Injury require Hospital/Physician? Yes: _____ No: _____
Hospital Name: _____
Address: _____

Important Notes and Instructions:

Prepared By: _____ Date: _____
Cell Number: _____ Email: _____