

RUGBY CANADA INJURY REPORT

CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF THE INJURY DATE

INJURED PARTICIPANT: Player Team Official Game Official **DATE OF INJURY:** ____/____/____
 Spectator Volunteer Employee

Name: _____ Parent/Guardian: _____

Date of Birth: ____/____/____ Sex: (M) (F)

Address: _____ City/Town: _____

Province: _____ Postal Code: _____ Phone Number: (____) _____

Fax: (____) _____ E-mail: _____

*** IMPORTANT* FORMS INCLUDING MEMBERSHIP NUMBER, MUST BE COMPLETED IN FULL OR FORM WILL BE RETURNED.**

This form must be completed for each case where a player, spectator or any other person at a sanctioned rugby activity, sustains an injury. Once completed a copy is to be sent to your Provincial Union. This form can be completed as follows: a) If the injured party is a player, team employee or volunteer, the form can be completed and signed by injured party, their coach or club administrator b) If the injured party is a spectator, the form can be completed and signed by the spectator, coach or club administrator of the home team.

Provincial Union: _____ **(If Player) Team Name:** _____

BODY PART INJURED:

Head	Back	Trunk	Arm	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Pelvis	Leg	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Eye Area <input type="checkbox"/> Face	<input type="checkbox"/> Neck	<input type="checkbox"/> Ribs	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Hand/Finger	<input type="checkbox"/> Hip	<input type="checkbox"/> Thigh	<input type="checkbox"/> Foot		
<input type="checkbox"/> Throat <input type="checkbox"/> Dental	<input type="checkbox"/> Upper	<input type="checkbox"/> Chest	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Forearm/Wrist	<input type="checkbox"/> Groin	<input type="checkbox"/> Knee	<input type="checkbox"/> Toe		
<input type="checkbox"/> Ear	<input type="checkbox"/> Lower	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Elbow	<input type="checkbox"/> Collarbone		<input type="checkbox"/> Shin	<input type="checkbox"/> Other		

NATURE OF CONDITION: Concussion Contusion Fracture
 Internal Organ Injury Strain Laceration Dislocation Sprain
 Separation Death Spinal Injury

ON-SITE CARE: On-Site Care Only Refused Care
 Sent to Hospital by: Ground Ambulance Air Ambulance
 Car

WHERE INCIDENT OCCURRED: Pitch Locker Room Stands Concession Area Parking Lot City Name: _____
 Exhibition / Regular Season **Playoffs / Tournament** **Practice** **Try-Outs** **Other**
 Warm-Up 1st Half 2nd Half Injury Time _____
 Pacific Time / Mountain Time / Central Time / Eastern Time / Newfoundland Time / Labrador Time

WEARING WHEN INJURED: Head Gear Contact Suit Mouth Guard Shoulder Pads Other: _____

Was the injured player in the correct league and level for their age? Yes No **Was this a sanctioned Rugby Canada activity?** Yes No

CAUSE OF INJURY:

Collision Collision w/ Own Player Collision w/ Opponent
 Hit by Ball Fall on Pitch Non-Contact Injury
 Tackled from Behind Fight Blindsiding Other _____

ADDITIONAL INFORMATION:

Has the player sustained injury before? Yes No
 If "Yes" how long ago _____
 Was a penalty called as a result of the incident? Yes No
 Estimated absence from rugby? 1 Week 1-3 Weeks 3+ Weeks

DESCRIBE HOW ACCIDENT HAPPENED: (Attach page if necessary)

TEAM INFORMATION: (To be completed by a Team Official) Union: _____

Team Name: _____ Team Official: _____ Team Official Position: _____

Team Official's Contact Number: (____) _____ Opposing Team: _____

HEALTH INSURANCE INFORMATION: * THIS MUST BE COMPLETED IN FULL OR FORM PROCESSING WILL BE DELAYED*

Occupation: Employed Full-Time Employed Part-Time Employer (If minor, list parent's employer): _____ Unemployed Full-Time Student
 Government Health Insurance Plan Number: _____

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)

BRANCH APPROVAL:

Membership Number: _____

If Member, Date of Enrollment: ____/____/____
 Month Day Year