Futsal Club Toronto

Injury Report Form

This form must be completed for all injuries occurring at a soccer event and requiring an evaluation by a Physician or Health Practitioner (e.g. 911 is called, player taken to hospital/clinic, concussion suspected). A Team Official (Trainer, Coach, Assistant Coach, Manager) who witnessed the incident must complete this form and submit it to the FCT office within 72 hours. Send form admin@futsalclubtoronto.com and samira@futsalclubtoronto.com

Date: _____ Time: _____

Player's Full Name: _____

Location of Accident: _____

_____

List Injuries (i.e. Cut, fracture, sprain, etc.): _____

_____

_____

Describe Incident / Mechanism of injury (E.g. Head-to-head collision, fell awkwardly on right ankle, etc.): _____

_____

_____

Emergency Medical Services called? Yes _____ No _____

Hospital / Clinic (where player being transported): _____

Mode of Transportation to Hospital / Clinic: _____

Parents / Guardians of Player: _____

Advised: Yes _____ No _____

TEAM INFORMATION: □ Competitive □ Recreational

Team Name/Age: _____ Opposing Team: _____

Name of Team Official completing this form: _____

Team Official Position: _____

Signature: _____

(1) Witness Name: _____ Witness Ph #: _____

(2) Witness Name: _____ Witness Ph #: _____

☐If the player sustained a concussive injury outside of a soccer-related event (e.g. at school, at home, etc.), please check this box, complete relevant sections of the form, and send to FCT; concussion protocol will need to be followed; player is not eligible for OSA insurance.

ADDITIONAL NOTES:

Office Use Only

Date Received: _____

Received By: _____