

SAFETY REQUIRES TEAMWORK

AN EMERGENCY ACTION PLAN FOR HOCKEY



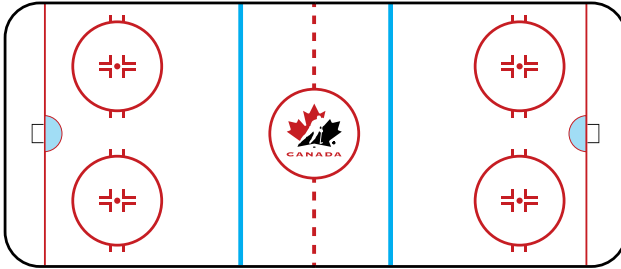
The coach, manager and hockey trainer should initiate a meeting at the beginning of the season to ensure they have the volunteers required for their Emergency Action Plan.

Equipment Locations

Please locate and identify area on map:

Legend

Phone P
Exits E
First aid... FA
AED. AED



Arena Information

Arena/Facility Name: _____

Address: _____

Telephone Number: _____

Emergency Telephone Numbers

Emergency: _____

Ambulance: _____

Fire Dept: _____

Hospital: _____

Police: _____

General: _____

Roles

Hockey Trainer / Charge Person

- Initially takes control of the situation.
- Instructs player to lay still and bystanders, such as other players, not to move player.
- Do not move the athlete.
- Assess injury status of player, decide if an ambulance/medical care is required.
- If the injury is serious and warrants immediate attention that you are not qualified to provide, make your pre-determined signal to your call person, control person and your pre-determined first aid/medical person.

Call Person

- Makes call when emergency assistance required (tests their cell phone in the facility to ensure it will work).
- Know location of alternate phones in the facility being played in. Have change or a phone card if necessary.
- Ideally at all games and practices and not involved on the bench.
- Has a list of emergency phone numbers in the area of the facility.
- Has a diagram displaying specific directions and best route to the arena facility.

Control Person

- Pre-determine the location of the AED and other emergency equipment in the facility.
- Retrieving the AED and/or first aid kit and bringing to the injured player if requested.
- Seek highly-trained medical personnel in the facility if requested by the Charge Person.
- Ensure teammates, other participants and spectators are not in the way of the charge person.
- Advise opponents, on-ice officials, arena staff and parents of the steps being taken.
- Ensure the quickest and best route for the ambulance crew to the ice surface is clear and accessible.
- Meet the ambulance on its arrival and direct EMS to the injured player.

IMPORTANT REMINDERS

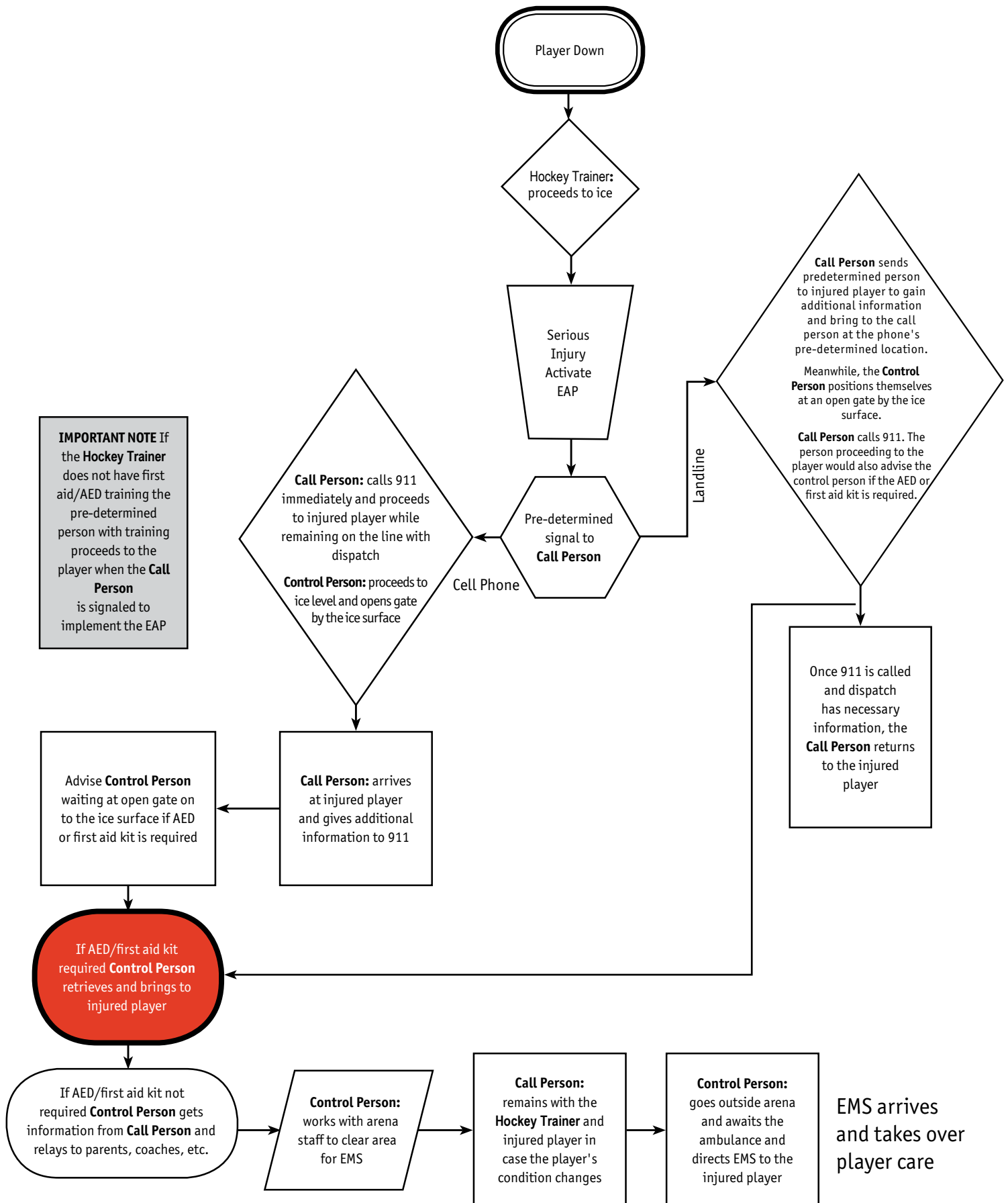
The game official continues to assume the role of being in charge of the overall environment.

It is important for officials to note that if the hockey trainer makes the signal for assistance that there may be a number of pre-determined people who will respond and will require access to the ice.

Once the ambulance is called, the officials should send both teams to their dressing rooms.

See flow chart on reverse

Emergency Action Plan Flow Chart





Emergency Action Plan Flow Chart

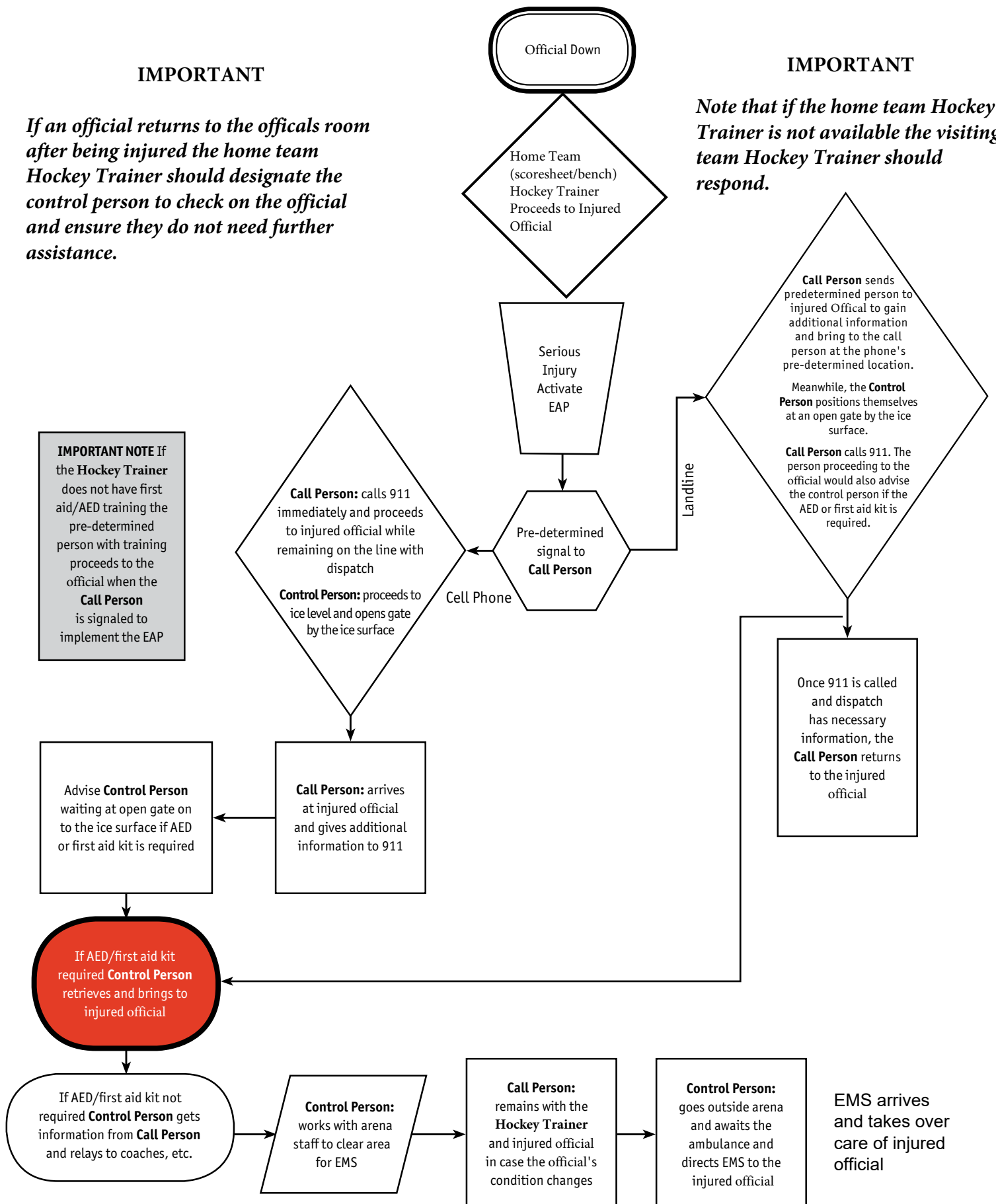


IMPORTANT

If an official returns to the officials room after being injured the home team Hockey Trainer should designate the control person to check on the official and ensure they do not need further assistance.

IMPORTANT

Note that if the home team Hockey Trainer is not available the visiting team Hockey Trainer should respond.





MEDICAL INFORMATION SHEET

Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____

Telephone: (_____) _____ Cell: (_____) _____

Provincial Health Number (optional): _____

Parent/Guardian #1: Name _____

Business Phone Number: (_____) _____

Parent/Guardian #2: Name _____

Business Phone Number: (_____) _____

Alternate emergency contact (if parents are not available)

Name: _____

Relationship to Player: _____

Telephone: (_____) _____ Cell: (_____) _____

Doctor's Name: _____

Telephone: (_____) _____

Dentist's Name: _____

Telephone: (_____) _____

Date of last complete physical examination: _____

Before a player participates in a hockey program it is recommended that they have a medical and that they also have any medical condition or injury problem checked by their family physician

Please check the appropriate response and provide details below if you answer "Yes" to any of the questions.

Yes ☐ No ☐ Medication

Yes ☐ No ☐ Allergies

Yes ☐ No ☐ Previous history of concussions

Yes ☐ No ☐ Fainting or seizure during or after physical activity

Yes ☐ No ☐ Near fainting or Brownouts

Yes ☐ No ☐ Seizures and/or epilepsy

Yes ☐ No ☐ Wears glasses

Yes ☐ No ☐ Are lenses shatterproof

Yes ☐ No ☐ Wears contact lenses

Yes ☐ No ☐ Wears dental appliance

Yes ☐ No ☐ Hearing problem

Yes ☐ No ☐ Asthma

Yes ☐ No ☐ Trouble breathing during exercise

Yes ☐ No ☐ Heart Condition

Yes ☐ No ☐ Palpitations or Racing Heart

Yes ☐ No ☐ Family history of heart disease

Yes ☐ No ☐ Family history of unexpected death during physical activity

Yes ☐ No ☐ Family history of unexplained death of a young person

Yes ☐ No ☐ Diabetes – Type 1 _____ Type 2 _____

Yes ☐ No ☐ Wears medical information bracelet/necklace
For what purpose? _____

Yes ☐ No ☐ Health problem that would interfere with participation on a hockey team

Yes ☐ No ☐ Has had an illness that lasted more than a week and required medical attention in the past year

Yes ☐ No ☐ Has had injuries requiring medical attention in the past year

Yes ☐ No ☐ Been admitted to hospital in the last year

Yes ☐ No ☐ Surgery in the last year

Yes ☐ No ☐ Presently injured
Injured body part: _____

Yes ☐ No ☐ Vaccinations up to date
Date of last Tetanus Shot: _____

Yes ☐ No ☐ Hepatitis B vaccination

Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)

Medications: _____

Recent injuries: _____

Allergies: _____

Any information not covered above: _____

Medical conditions: _____

I understand that it is my responsibility to keep the team Safety Person advised of any change in the above information as soon as possible. In the event of a medical emergency and that no one can be contacted, team management will arrange to take my child to the hospital or a physician if deemed necessary. I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child. I also authorize release of information to appropriate people (coach, physician) as deemed necessary.

Date: _____

Signature of Player: _____

Date: _____

Signature of Parent or Guardian: _____

Disclaimer: Personal information used, disclosed, secured or retained by Hockey Canada will be held solely for the purposes for which we collected it and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act as well as Hockey Canada's own Privacy Policy.



HOCKEY TRAINERS CERTIFICATION PROGRAM

Player / Team Injury Log

Player/Team: _____ Hockey Trainer: _____

Date	Name	Injury Description	Management (ice/bandage/tape)	Follow-up/ Recommendations	Hockey Canada Injury Report and HTCP IDCP Report Form Submitted	Return to play form		Hockey Trainers Initials
						Requested	Received	

Note: This log should report, **at minimum**, each time;

- A player is removed for the remainder of the game due to an injury sustained during play.
- A player is injured during a practice whether on or off ice.
- A player is forced to leave a game or practice for unknown medical reasons.
- A player is injured during a hockey related event.

Note: If an injury requires medical referral and/or hospitalization, complete and submit a Hockey Canada Injury Report.



HOCKEY CANADA INJURY REPORT



See reverse for mailing address.

Forms must be filled out in full or form will be returned. This form must be completed for each case where an injury is sustained by a player, spectator or any other person at a sanctioned hockey activity.

CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF THE INJURY DATE.

DATE OF INJURY: ___/___/___
Mo. Day Yr.

INJURED PARTICIPANT: Player Team Official Game Official Spectator

Name: _____ Birthdate: ___/___/___ Gender: M F
Mo. Day Yr.

Address: _____

City / Town: _____ Province: _____ Postal Code: _____ Phone: () _____

Parent / Guardian: _____ Email Address: _____

AGE DIVISION

Under-7 Under-9 Under-11 Under-13 Adult Rec
Under-15 Under-18 Under-21 Junior Senior

CATEGORY

AAA A BB CC DD House Minor Junior
AA B C D E Major Junior Other _____

BODY PART INJURED

Arm:		Leg:		Head:	Trunk:	Back:
Left	Right	Left	Right			
Shoulder	Shoulder	Shin	Shin	Eye Area	Abdomen	Neck
Upper arm	Upper arm	Knee	Knee	Face	Chest	Lower
Collarbone	Collarbone	Toe	Toe	Throat	Ribs	Upper
Elbow	Elbow	Thigh	Thigh	Skull	Pelvis:	
Hand/Finger	Hand/Finger	Foot	Foot	Dental	Hip	Groin
Forearm/Wrist	Forearm/Wrist			Other:		

NATURE OF CONDITION

Concussion Laceration Fracture
Sprain Strain Contusion
Dislocation Separation Internal Organ Injury

ON-SITE CARE

On-Site Care Only Refused Care

Sent to Hospital by: Ambulance Car

INJURY CONDITIONS

Name of arena/location: _____

- | | |
|--|--|
| <input type="checkbox"/> Exhibition/Regular Season | <input type="checkbox"/> Period #2 |
| <input type="checkbox"/> Playoffs/Tournament | <input type="checkbox"/> Period #3 |
| <input type="checkbox"/> Practice | <input type="checkbox"/> Overtime: _____ |
| <input type="checkbox"/> Try-outs | <input type="checkbox"/> Dry Land Training |
| <input type="checkbox"/> Other | <input type="checkbox"/> Gradual Onset |
| <input type="checkbox"/> Warm-up | <input type="checkbox"/> Other Sport |
| <input type="checkbox"/> Period #1 | <input type="checkbox"/> Other: _____ |

CAUSE OF INJURY

Hit by Puck
Collision with Boards
Non-Contact Injury
Hit by Stick
Collision on Open Ice
Collision with Opponent
Fall on Ice
Checked from Behind
Collision with Net
Fight
Blindsiding

Was the injured player in the correct league and level for their age group?
☐ Yes ☐ No

Was this a sanctioned Hockey Canada activity?
☐ Yes ☐ No

LOCATION

- | | | |
|---|--|---|
| <input type="checkbox"/> Defensive Zone | <input type="checkbox"/> Offensive Zone | <input type="checkbox"/> Neutral Zone |
| <input type="checkbox"/> Behind the Net | <input type="checkbox"/> 3 ft. from Boards | <input type="checkbox"/> Spectator Area |
| <input type="checkbox"/> Parking Lot | <input type="checkbox"/> Dressing Room | <input type="checkbox"/> Bench |
| <input type="checkbox"/> Other: _____ | | |

WEARING WHEN INJURED

- ☐ Full Face Mask
☐ Helmet/No Face Shield
☐ No Helmet/No Face Shield
☐ Intra-Oral Mouth Guard
☐ Half Face Shield/Visor
☐ Throat Protector
☐ Short Gloves
☐ Long Gloves

ADDITIONAL INFORMATION

Has the player sustained this injury before? ☐ Yes ☐ No
If "Yes" how long ago? _____
Was a penalty called as a result of the incident? ☐ Yes ☐ No
Estimated absence from hockey?
☐ 1 week ☐ 1-3 weeks ☐ 3+ weeks

DESCRIBE HOW INCIDENT HAPPENED

(Attached additional page if necessary)

I hereby authorize any Health Care Facility, Physician, Dentist or other person who has attended or examined me/my child, to furnish Hockey Canada any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all dental, hospital, and medical records. A photo static/electronic copy of this authorization shall be considered as effective and valid as the original.

Signed: _____
(Parent/Guardian if under 18 years of age)
Date: _____

TEAM INFORMATION

(To be completed by a Team Official)

Association: _____

Team Name: _____

Team Official (Print): _____

Team Official Position: _____

Signature: _____

Date: _____

HEALTH INSURANCE INFORMATION

THIS MUST BE FILLED OUT IN FULL OR FORM PROCESSING WILL BE DELAYED

Occupation: ☐ Employed Full-time ☐ Employed Part-time
☐ Unemployed ☐ Full-Time Student

Employer (If minor, list parent's employer): _____

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.)

Make Claim Payable To: Injured Person Parent Team Other: _____

MEMBER APPROVAL



HOCKEY CANADA INJURY REPORT

Participant's name: _____



PHYSICIAN'S STATEMENT

Physician: _____ Address: _____ Tel: (____) _____

Name of Hospital / Clinic: _____ Address: _____

Nature of Injury: _____

Date of First Attendance: _____

Claimant will be totally disabled: _____

From: _____ To: _____

Is the injury permanent and irrecoverable? ☐ No ☐ Yes

Give the details of injury (degree): _____

Prognosis for recovery: _____

Did any disease or previous injury contribute to the current injury?

No Yes (describe): _____

Was the claimant hospitalized? No Yes

(give hospital name, address and date admitted): _____

Names and addresses of other physicians or surgeons, if any, who attended claimant: _____

I certify that the above information is correct and to the best of my knowledge,

Signed: _____ Date: _____

DENTIST STATEMENT

Limits of coverage: \$1,250 per tooth, \$3,000 per accident. Treatment must be completed within 52 weeks of accident. (Effective September 1st, 2018)

UNIQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO.

Patient

Last name Given name

Address

City / Town Province Postal Code

Dentist

Phone No

I hereby assign my benefits payable from this claim directly to the named dentist and authorize payment directly to him / her

SIGNATURE OF SUBSCRIBER

For dentist use only – for additional information, diagnosis, procedures or special consideration.

DUPLICATE FORM ☐

I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my dentist for the entire treatment. I acknowledge that the total fee of \$_____ is accurate and has been charged to me for the services rendered. I authorize release of the information contained in this claim form to my insuring company/plan administrator.

SIGNATURE OF (PATIENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE MO. / DAY / YR.	PROCEDURE	INITIAL TOOTH CODE	TOOTH SURFACE	DENTIST'S FEE	LAB CHARGE	TOTAL CHARGE

This is an accurate statement of services performed and the total fee due and payable & oe.
NOTE: All benefits subject to insurer payor status, provisions of the policy, Hockey Canada sanctioned events.

TOTAL FEE SUBMITTED

Mail completed form to: **ONTARIO WOMEN'S HOCKEY ASSOCIATION**

225 WATLINE AVENUE
MISSISSAUGA, ON
L4Z 1P3

TEL: (905) 282-9980
FAX: (905) 282-9982

INSURANCE@OWHA.ON.CA
OWHA.ON.CA

HOCKEY TRAINERS CERTIFICATION PROGRAM RETURN TO PLAY

Name of Player

is able to return to play following injuries sustained on

Date

Considerations /restrictions with respect to return to play:

Name of Medical Authority

Type of Medical Authority

Date: _____

Signature

This information is strictly confidential and will only be used to assist in the player's safe return to play. All records will be returned to the player.

NOTE: The HTCP recommends that this be completed by a physician, chiropractor, physiotherapist or nurse practitioner for muscular or skeletal injuries (excluding fractures). Fractures as well as all neurological injuries including spinal injuries and concussions must be signed off by a physician.

Disclaimer: Personal information used, disclosed, secured or retained will be held solely for the purposes for which we collected it and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act.