Garden City Minor Hockey Association

P.O. Box 27025 Lakeport Post Office 600 Ontario Street
St. Catharines, Ontario L2N 7P8
905-646-7264 www.gcmha.ca

GCMHA Concussion Policy

Parental Responsibility of Concussion Care

Informed Refusal Agreement

Elements of Risk Notice

The risk of injury exists in every athletic activity. However, due to the very nature of certain activities, the risk of injury may increase. Injuries may range from minor sprains and strains to more serious injuries. These injuries result from the nature of the activity and can occur without fault on either the part of the athlete, the sport organization or its employees or agents or the facility where the activity is taking place. Ice hockey is one of the activities that has been identified as having the potential for more serious consequences, particularly with respect to concussions. The safety and well-being of our players is a prime concern for GCMHA and attempts are made to manage, as effectively as possible, the foreseeable risks inherent in physical activity.

Garden City Minor Hockey Association has formed a collaborative partnership with Complete Concussion Management Inc (through the Niagara Health and Rehabilitation Clinic) because they are the leaders in concussion management for amateur sports associations across Canada. All protocols and stages are based on the most current scientific research and this policy has been enacted to help keep our kids safe; reducing the risk of concussion as well as the potentially permanent or fatal outcomes that may arise from improper management of these injuries.

Informed Refusal Agreement

1. I/we have read and understand the **Elements of Risk Notice** in playing ice hockey at GCMHA. _____ (Parent(s)' Initials)
2. I/we have read and understand that GCMHA strongly recommends participation in the NHRC Concussion Baseline Testing and Management Program for all players Minor Bantam and up. _____ (Parent(s)' Initials.)
3. I/we refuse to participate in the NHRC Concussion Baseline Testing and Management Program. _____ (Parent(s)' Initials.)
4. I/we understand that refusal in the NHRC Concussion Baseline Testing and Management Program means that my/our child does not have the benefit of baseline testing. _____ (Parent(s)' Initials.)
5. I/we hereby accept the risk inherent in playing ice hockey at GCMHA. _____ (Parent(s)' Initials.)
6. I/we hereby assume responsibility should my/our child be removed from play for a suspected concussion and agree to follow all steps in the GCMHA Concussion Protocol for Parental Care. _____ (Parent(s)' Initials.)

Execution of Agreement:

_____ Parent(s)' Name(s)

_____ Print

_____ Parent(s)' Signature(s)

_____ Witness' Name

_____ Witness' Name

_____ Witness' Signature

Signed at St. Catharines, Ontario, this _____ day of _____, 2016.

GARDEN CITY MINOR HOCKEY ASSOCIATION
Parental Responsibility of Concussion Care

STEP #1

DOCUMENTATION OF MEDICAL EXAMINATION FOR SUSPECTED CONCUSSION

This form to be provided to all students suspected of having a concussion. Please reference our Concussion Protocol for further information.

_____ (Player Name) from the _____ (team) sustained a suspected concussion on_____ (date). As a result, this Student must be seen by a medical doctor or other health care practitioner qualified in concussion diagnosis and management. Prior to returning to the play, the parent/guardian must inform the team trainer and GCMHA executive of the results of the medical examination by completing the following:

Results of Medical Examination

(Appropriate Diagnostic documentation required below)

- ☐ My child/ward has been examined and **no concussion** has been diagnosed and therefore may resume full participation in learning and physical activity with no restrictions. (NOTE: this form with the accompanying medical info MUST be returned to GCMHA before the player returns to the ice.

- ☐ My child/ward has been examined and **a concussion has been diagnosed** and therefore must begin a medically supervised, individualized and gradual Return to Play Activity Plan.

Parent/Guardian Signature:_____ **Date**_____

Medical Doctor, Health Care Practitioner Signature: _____

*Signature may be substituted by medical note with similar information regarding incident.

Date: _____

GARDEN CITY MINOR HOCKEY ASSOCIATION
Parental Responsibility of Concussion Care

STEP #2

DOCUMENTATION FOR A DIAGNOSED CONCUSSION
RETURN TO PLAY ACTIVITY PLAN

The Return to Play Activity Plan is a combined approach. Parts A and B must be completed prior to the player returning to ant GCMHA physical activity. Part B and C requires Physician or healthcare professional approval.

********** Each Part must take a minimum of 24 hours.**********

Part A – Physical and Cognitive Home Rest

- Completed at home.
- Cognitive Rest – includes limiting activities that require concentration and attention (e.g., reading, texting, television, computer, video/electronic games).
- Physical Rest – includes restricting recreational/leisure and competitive physical activities.

My child/ward has completed Part A – Physical and Cognitive Home Rest and his/her **symptoms have shown improvement**. My child/ward will proceed to Part B – Return to Limited Play.

Parent/Guardian Signature:_____ Date: _____

Part B – Return to Limited Play (non-Contact, Off Ice Only)

- Student returns to light team activities.
- Requires individualized athletic strategies and/or approaches which gradually increase levels of activity.
- Physical rest– includes restricting/ limiting recreational/leisure and physical activities.

My child/ward has been following individualized physical activity strategies and/or approaches and is **symptom free**. My child/ward will return to regular team physical activities. My child/ward will proceed to Part C – Return to Full Physical Activity.

Parent/Guardian Signature:_____ Date_____

Medical Doctor, Health Care Practitioner Signature: _____
*Signature may be substituted by medical note with similar information regarding incident.
*Must be the same individual that diagnosed the concussion (IF possible)

Date: _____

Part C – Return to Full Physical Activity

Medical Examination

I,_____ (medical doctor/ Health care practitioner name) have examined _____(child/ward) and confirm he/she continues to be symptom free and is able to return to regular physical activities and full contact AND/ OR non-contact training/practices for Hockey.

Medical Doctor/Nurse Practitioner Signature: _____
*Signature may be substituted by medical note with similar information regarding incident.
*Must be the same individual that diagnosed the concussion (IF possible)

Date: _____

Comments:

_____

_____

_____

_____

Parental Confirmation:

My child/ward _____is symptom free after participating in regular non-contact physical activities in non- contact sports and full training/practices for contact sports and is now permitted to return to FULL CONTACT physical activity with no restrictions.

Return of Symptoms*:*

I agree that should my child/ward experience a return of concussion signs and/or symptoms and has been examined by a medical doctor/nurse practitioner, who has advised a return to the beginning of Step #2

Parent/Guardian Signature: _____ Date_____

Comments:

_____

_____