SECTION: Administration

TITLE: Risk Management Concussion Prevention and Management Policy

PAGE: 1 of 1

POLICY NUMBER: 3.54

APPROVED BY: Executive

APPROVAL DATE: Feb 1, 2016

REVISION DATE:

POLICY:

Briers Basketball Club (Briers) adopts the current Ontario Basketball Association's (OBA) Concussion Prevention & Management Policy.

Purpose:

To provide standards for the prevention and management of sports related head injuries involved in organized youth sports through Briers.

PROCEDURE:
Responsible Person:

Executive Committee:

Inform all active Briers volunteers, i.e. convenors/coaches

Active Volunteer:

a) Be aware of, and follow the current OBA Concussion Prevention & Management Policy.
b) Completion of OBA Incident Report
c) Completion of Appendix A
d) Completion of Appendix B

Attachments:

1. Ontario Basketball Association Incident Report
2. Appendix A - Documentation of Medical Examination
3. Appendix B - Documentation for a Diagnosed Concussion Return

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ONTARIO BASKETBALL ASSOCIATION INCIDENT REPORT

Time and Place of Incident:
Date: _____ Time: _____ ❑AM ❑PM
Event: _____
Sanctioned by: _____ Location: _____

Happened To:
Name: _____
Age: _____ Sex: ❑Male ❑Female Phone: (_____) _____
Address: _____
City: _____ Province: _____ Postal Code: _____

Function:
As: ❑Participant ❑Volunteer ❑Spectator ❑Bystander ❑Official
❑Other: _____

Apparent Injury or Damage:
Body Part: _____
Condition: (Laceration, Concussion, Sprain, Fracture etc.): _____
❑On-Site Care ONLY, by: ❑Physician ❑EMT ❑Trainer ❑Other: _____
❑Ambulance, taken to: _____ City: _____
❑Fatality

Occasion
What was the situation and exact location at the time of the incident? _____
_____
_____

Incident Description:
Describe what happened: _____
_____
_____

Witnesses:
Name: _____ Name: _____
Address: _____ Address: _____
_____ _____
Phone: (_____) _____ Phone: (_____) _____

Insured:
Name of Insured: _____ Policy Number: _____
Club Name: _____ City/Prov: _____

Coach/Official/Team or League Representative:
Name: _____ Phone: (_____) _____
Title: _____ Organization: _____
Signature: _____ Date: _____

THIS FORM MUST INCLUDE THE INSURED NAME, POLICY NUMBER, AND SIGNATURE OF THE INSURED/REPRESENTATIVE BEFORE RETURNING OR PROCESSING MAY BE DELAYED

ACCIDENT MEDICAL INSURANCE CLAIM FORM

IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THIS CLAIM FORM BE FURNISHED

OMISSION OF VITAL INFORMATION WILL CAUSE DELAY IN CLAIM PROCESSING

TO BE COMPLETED BY INJURED PERSON OR PARENT

PART II

COVERAGE UNDER THE POLICY IS EXCESS OVER ALL OTHER HEALTH & ACCIDENT INSURANCE AVAILABLE. YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN OR YOUR PARENT'S PERSONAL HEALTH PLAN, YOUR EMPLOYER OR GOVERNMENTAL HEALTH PLAN. AFTER OTHER INSURANCE BENEFITS HAVE BEEN SUBMITTED, YOU SHOULD FORWARD A COPY OF THE OTHER INSURANCE COMPANY'S EXPLANATION OF BENEFITS AND THE CORRESPONDING ITEMIZED MEDICAL STATEMENTS. IF YOUR INSURANCE COMPANY DENIES BENEFITS, SEND A COPY OF THEIR DENIAL. IF THERE IS NO OTHER INSURANCE, THIS POLICY WILL ACT AS PRIMARY INSURANCE. NOTE: COVERAGE MAY ALSO INCLUDE A POLICY DEDUCTIBLE.

WE WILL NOT PROCESS YOUR CLAIM WITHOUT EMPLOYER INFORMATION. IT IS IMPERATIVE THAT WE RECEIVE ALL DATA REQUESTED. TIMELY RECEIPT OF REQUESTED INFORMATION WILL HELP EXPEDITE PROCESSING OF YOUR CLAIM.

INJURED PERSON: _____

FATHER'S NAME (if injured is a minor): _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

CITY: _____ PROV: _____ PC: _____

PHONE: (_____) _____

GROUP INSURANCE COMPANY: _____

POLICY NUMBER: _____

INSURANCE COMPANY ADDRESS: _____

CITY: _____ PROV: _____ PC: _____

SIGNATURE: _____

SPOUSE'S NAME (if applicable): _____

MOTHER'S NAME (if injured is a minor): _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

CITY: _____ PROV: _____ PC: _____

PHONE: (_____) _____

GROUP INSURANCE COMPANY: _____

POLICY NUMBER: _____

INSURANCE COMPANY ADDRESS: _____

CITY: _____ PROV: _____ PC: _____

SIGNATURE: _____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER, ANY AND ALL INFORMATION WITH RESPECT TO THE ACCIDENTAL INJURY FOR WHICH I AM CLAIMING INSURANCE BENEFITS.

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER, ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL, MEDICAL, OR INSURANCE RECORDS INCLUDING, BUT NOT LIMITED TO, INFORMATION REGARDING OTHER INSURANCE COVERAGES. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF INFORMATION NEEDED TO QUICKLY MY CLAIM.

SIGNATURE: _____ DATE: _____

Please Note: If injured person is a minor, signature must be of parent or legal guardian

Appendix A

Documentation of Medical Examination

This form to be provided to all individuals suspected of having a concussion.

(Name) _____ sustained a suspected concussion on

(Date) _____ (d/m/year).

As a result, this person must be seen by a medical doctor or nurse practitioner. Prior to returning/participating in a Briers Basketball Club (Briers) activity, the parent/guardian must inform Briers of the results of the medical examination by completing the following:

Results of Medical Examination

☐ My child/ward has been examined and no concussion has been diagnosed and therefore may resume full participation for contact sports with no restrictions.

☐ My child/ward has been examined and a concussion has been diagnosed and therefore unable to participate until further notice.

Comments:

Date: _____ (d/m/year)

X _____

Parent/Guardian Signature:

Appendix B

Documentation for a Diagnosed Concussion Return

This form is to be used by parents/guardians to communicate their child's/ward's progress.

Medical Examination

☐ I, _____ (medical doctor/nurse practitioner name) have examined _____ (name) and confirm he/she is able to resume full participation for contact sports with no restrictions.

Comments:

Date: _____ (d/m/year)

X _____

Medical Doctor/Nurse Practitioner Signature: