UCYSL/UC PREMIER

Injury Report

Date/Time:
Incident:_____
Location/Field:_____

Coach/Team
Name:_____

Club/League: _____

Name(s) of the player involved in
incident/situation:

_____

Description of incident/injury:

_____
_____
_____
_____

Treatment given:

_____
_____

I, _____, acknowledge that I have received and been informed of a head injury to my son/ daughter on (date) _____. I also understand that my son/ daughter will not be allowed to return to play without a note from a Certified Medical Professional that my son/ daughter has completed a graduated Return to Play Protocol of at least seven days.

***Parent's Signature*:_____** **Date:_____**

By submitting this form, you agree to the following terms and conditions:

This form and any supporting and related information may be shared with your club/organization.

You certify that the information submitted via this form, as well as any supporting and related information submitted with it, is true and accurate to the best of your knowledge.

Coach's Signature:_____

Witness name: _____

Please submit this completed form, as well as any other supplemental information, via one of the methods below:

Via email to risk@ucysl.org
Or
Via mail/expedited shipping to:
Attn Risk Management Reporting
PO Box 546, Union City CA 94587