MEDICAL WITHDRAWAL FORM

Please forward the form to Key City Gymnastics within 5 days of the injury, accompanied by a supporting Drs. Note

SUBMIT COMPLETED FORM TO:
Key City Gymnastics Club
415 Industrial Road A
Cranbrook, BC V1C 4X8
programming@keycitygym.ca
Fax: 250-426-2096

First Name: Last Name: BC#:
Address: City: Prov: PC:
Phone # DOB (mm/dd/yyyy):
Name of Coach – if injury in gym Phone #:
NCCP#: Certification: Coach BC#:
Witness Name: Witness Phone#:
Club/Site Name:
What time did injury occur?
Injury Occurred During: ☐ Out of Gym Activity ☐ Gymnastics Practice ☐ Club Sanctioned Event

Program: ☐ Active Start ☐ Recreational ☐ Parkour ☐ Trampoline ☐ Competitive ☐ Dance ☐ Out of Club
Event/Location:
Surface (ex. mats, floor, apparatus, playground, grass/snow):

Describe HOW the injury happened and the what was the skill/activity the individual was involved in:

_____
_____
_____
_____
_____
_____
_____

Activity Involved:

_____
_____
_____
_____

Situation:
☐ Fall (slip/trip/pushed/lost balance) ☐ At home or at play
☐ Over/under rotated skill ☐ Collision with person
☐ Collision with other object ☐ Non-contact injury
☐ Other, please specify: _____

Injured Body Part:

☐ Head	☐ Face	☐ Teeth	☐ Neck	
☐ Left	☐ Forearm	☐ Elbow	☐ Hand	☐ Finger
☐ Right	☐ Shoulder	☐ Chest	☐ Abdomen	☐ Spine
☐ Both	☐ Buttocks	☐ Hamstring	☐ Thigh	☐ Knee
☐ N/A	☐ Calf	☐ Foot	☐ Ankle	☐ Toe

Nature of Injury:
☐ Sprain/strain ☐ Dislocation ☐ Fracture
☐ Concussion/head injury ☐ Other, please specify:

_____

Injury Classification:
☐ New injury ☐ Re-injury ☐ Acute injury ☐ Chronic injury
☐ Recurrent injury sport ☐ Recurrent injury non-sport
☐ Complication of prior injury

Symptoms:
☐ Shortness of breath ☐ Loss of feeling
☐ Pain ☐ Dizziness ☐ Loss of consciousness/fainting
☐ Other, please specify: _____

Initial Treatment:
☐ RICE (Rest, Immobilize, Cold, Elevate)
☐ CPR ☐ Manual Therapy ☐ Sling/splint ☐ Wrapping/taping
☐ Dressing ☐ Stretch/exercise ☐ None - referred elsewhere

Disposition:
☐ Self-transport ☐ EMS care ☐ On-site only ☐ Hospital care
☐ Refused care ☐ Other, please specify:

Referral:
☐ Specialist ☐ Physiotherapist ☐ No referral
☐ Other, please specify: _____

FOLLOW UP after the incident and report results, if applicable: _____
_____

Date of Injury:_____ **Current Date:**_____
Parent Name (print):_____ **Signature:**_____