

Male: Female:

race / Rennen: _____

track / Bahn: _____ date / Datum: _____

injury registration document**Verletzungsmeldung**

(Must be completed by the Race Doctor for each athlete consultation, during all training and race days)

Name: _____

 Disziplin: 2-man Bobsleigh 2-woman Bobsleigh 4-man Bobsleigh
 Monobob Para Sport Skeleton

Age: _____ Country: _____

| | | | |
|--|---|--|--|
| Type of injury <input type="checkbox"/> Abrasion <input type="checkbox"/> Cut <input type="checkbox"/> Contusion <input type="checkbox"/> Distortion <input type="checkbox"/> Luxation <input type="checkbox"/> Fracture <input type="checkbox"/> Shock <input type="checkbox"/> Other _____ | Anatomical Location of injury <input type="checkbox"/> Head <input type="checkbox"/> face <input type="checkbox"/> Neck <input type="checkbox"/> Spine <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic/Lumbar Spine <input type="checkbox"/> Thorax <input type="checkbox"/> Abdomen / Pelvis <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Other _____ | Head Injury symptoms / concussion <input type="checkbox"/> Headache <input type="checkbox"/> Neck pain <input type="checkbox"/> Confusion <input type="checkbox"/> Impaired Intellectual Activity <input type="checkbox"/> Amnesia <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Other _____ Last head injury or concussion _____ | Suspect Concussion? Re-Test should be done IMPACT <input type="checkbox"/> yes <input type="checkbox"/> no |
|--|---|--|--|

Treatment at track:

| | | | |
|--|---|------------------------------------|-----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Suture | <input type="checkbox"/> Injection | Sent to: |
| <input type="checkbox"/> oral Medication | <input type="checkbox"/> Splinting | <input type="checkbox"/> Taping | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> Bandage | <input type="checkbox"/> Intubation | <input type="checkbox"/> Infusion | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Oxygen | <input type="checkbox"/> Observation for Cervical/Spinal Injury | | <input type="checkbox"/> CT-MRI |
| <input type="checkbox"/> Observation for Head Injury | | | <input type="checkbox"/> Other |

Time of Injury:

 Warm Up Crash
 Start Other pleas describe: _____

In case of crash – every athlete needs to be checked by race doctor

 I feel good, was checked by medical team and want to go back to sliding. (only possible if Race Doctor has not detected any injury, concussion or similar which prohibits athlete from sliding)
 I was checked by the medical team and am unable to go back to sliding.
 Athletes Signature: _____ By signing I authorise the release of all information including personal health information in this document to the IBSF.

The Race Doctor herewith confirms that the athlete has been medically checked and is allowed to slide **is NOT allowed to slide**

Doctors name/stamp (please print readable if queries):

 Datum: _____ Signature: _____Send by email to IBSF office office@ibsf.org and to IBSF Medical Committee dreugenebyrne@gmail.com