

Athlete Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ (dd/mm/yy)

Age: \_\_\_\_\_\_\_ Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Team Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONFIDENTIAL MEDICAL INFORMATION AND CONCUSSION HISTORY**

**Please complete the following questions as fully and carefully as possible in order to help us effectively interpret the results of your baseline assessment. This information will remain strictly confidential.**

Concussion History: include month/year, how it happened, symptoms experienced, and length of recovery:

☐ No known concussions

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do any of the following conditions apply? (please indicate)

☐ ADD/ADHD ☐ Clinical Depression/Anxiety ☐Migraine Headaches ☐Learning Disability ☐ Sleep Disorder

☐ Dyslexia ☐ Repeated one or more grade levels ☐ Received speech therapy

☐ Individual Education Plan (IEP) ☐ Motion Sickness / Car Sickness ☐ Visual Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate your level of academic performance:

☐ Below average (C/D Student) ☐ Average (B/C Student) ☐ Above Average (A/B Student)

PLEASE REVIEW BELOW, SIGN, AND RETURN

**I hereby consent to the administration and supervision of a concussion baseline test by *Shift Concussion Management*.** I understand that baseline testing does not prevent concussive injuries, but allows healthcare professionals to better manage the injury should it occur.

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SIGNED PRINT NAME DATE

For Athletes under the age of 16: PLEASE HAVE PARENT/GUARDIAN SIGN ABOVE\*