ST MARGARET'S BAY
Chiropractic Centre
BODY • FAMILY • LIFE

Keep your Head in the Game Concussion Screening **HISTORY & PERMISSION**

Player Name

Team Name

Address

Parent/Guardian Name

I, _____, as parent/guardian for the above named player, consent to **St. Margaret's Bay Chiropractic Centre** performing screening testing for neck and head injuries on this player. I understand that this is a screening procedure only, one tool in the detection of potential neck or head injuries. A full diagnosis will require additional testing and examination. *

Signature _____ Date _____

Player Health History

circle appropriate

Has this player ever suffered a previous known concussion? Y N
Has this player ever suffered a previous suspected concussion? Y N
Has this player ever lost consciousness? Y N
Has this player ever been involved in an accident? (including car, ATV, bike, etc.) Y N
Has this player ever complained of neck pain? Y N
Has this player ever complained of neck stiffness? Y N
Has this player ever noted arm or hand pain that radiates? Y N
Has this player ever exhibited the following:
- Chronic or recurrent headache Y N
- Nausea or vomiting after exertion Y N
- Dizziness or vertigo Y N
- Disorientation or confusion Y N

Please elaborate on any previous concussions

Has this player ever been to see a chiropractor? Y N
If yes, why?

*Please ensure this form returns with the player on the day of concussion testing. Players without signed parental consent will not be tested.

**SCAT 2 - http://www.cces.ca/files/pdfs/SCAT2[1].pdf

For your whole body, your whole family, your whole life.

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