

CONCUSSION POLICY & ImPACT™ TESTING CONSENT FORM

Last Name: _____ First Name: _____

Date of Birth: _____ / _____ / _____

I/We acknowledge that we have been informed of the _____ policy for prevention and care of mild traumatic brain injury during interscholastic athletics participation (the "_____ Concussion Policy"). I/We hereby agree to abide by the guidelines established within the _____ Concussion Policy. I/We also understand that these policies may at times be modified to provide more complete care to the student-athletes of _____ and we will be notified of changes to this policy through the _____ website.

I/We give permission for (name of child) _____ to have baseline and post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) testing administered at _____. I understand that my child may need to be tested more than once, depending upon the results of the test, as compared to my child's baseline test, which will be kept on file at _____. I understand there is no charge for the testing administered at _____. I further understand that educational information regarding ImPACT and mild traumatic brain injury are available to me at any time from the _____ sports medicine staff.

_____ may release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to the _____ sports medicine staff, as well as my child's primary care physician, neurologist, or other treating physician, as I may indicated to the _____ sports medicine staff. I also acknowledge that my child's clearance for participation in sport following any mild traumatic brain injury is subject to approval from the physician(s) recognized as sports medicine providers for _____.

I understand that general information about the test data may be provided to my child's guidance counselor and teachers, for the purposes of providing temporary academic modifications, if necessary.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____