

CONSENT FORM

For use of the Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT™)

I have read the attached information. I understand its contents. I have been given an opportunity to ask questions and all questions have been answered to my satisfaction. I understand that participation in the ImPACT™ concussion baseline testing is highly recommended but not required for athletes in Cherokee County schools.

I also understand that the ImPACT™ testing is merely a tool to assist Medical Professionals in the diagnosis and subsequent treatment of potentially serious injuries, the ImPACT™ testing IS NOT a substitute for treatment by a medical professional. I **acknowledge that if my child is suspected of receiving a concussion causing injury, my child WILL NOT be allowed to participate in athletics until cleared by a medical doctor.**

ATHLETE'S NAME: _____

SCHOOL: _____ GRADE: _____

Address: _____

Sport(s) _____

Please INITIAL one of the boxes below, sign, date and return to the coach or athletic trainer for your child's team.

YES, I give permission for my child, named above, to participate in baseline testing with the ImPACT program.

NO, I do not give permission for my child to participate in baseline testing.

PARENT/GUARDIAN NAME _____
(Please print)

Signature: _____ Date: _____

Email: _____ Phone: _____