ImPACT CONCUSSION TESTING CONSENT

NAME:_____ DOB:_____

ADDRESS:_____ PHONE #_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____

EMERGENCY CONTACT PHONE #_____

PHYSICIAN:_____ PHONE #_____

*Results from the Athlete's baseline test will be shared with Primary Care Physician and/or HGB ImPACT Credentialed Physician for possible future care.

Testing lasts for about 1 hour, PLEASE BE ON TIME/EARLY

Any follow-up or post testing is at the cost of the student athlete. It is the responsibility of the parent/guardian to maintain adequate health and/or accident insurance to ensure proper care of the student athlete(s). Furthermore, parents/guardians and student athletes are hereby notified that the risk of serious bodily injury and/or accidental death is inherent in athletic activities, particularly contact sports.

As the parent/guardian, I understand that the ImPACT Concussion baseline test is mandatory for all contact sports (Football, Soccer, Wrestling, Basketball, Volleyball, Baseball, Softball, and Cheer) and that failure to participate in this testing will result in your student athlete's inability to participate. I further understand that this ImPACT Concussion baseline test will be provided at no cost to the student athlete. I agree to participate in the ImPACT testing.

Printed Name of Athlete:_____

Signature of Athlete:_____ Date:_____

Parent Printed Name:_____

Signature of Parent:_____ Date:_____

PLEASE RETURN THIS FORM TO THE HIGH SCHOOL ATHLETIC OFFICE OR THE MIDDLE SCHOOL FRONT OFFICE