SHADOW RIDGE
HIGH SCHOOL

Consent for Cognitive Testing and Release of Information

Banner Concussion Center launched the most comprehensive concussion prevention, treatment and education program for young athletes in the nation. Under the leadership of Banner physicians, the Dysart District will include mandatory concussion education, voluntary pre-injury testing and post-injury medical resources to each of the high schools. All Dysart high school athletes will have the opportunity to undergo ImPACT testing. This is a concussion evaluation system that helps to determine when an athlete is well enough to return to play following a concussion.

Dysart athletes who undergo the voluntary ImPACT testing will first take a baseline test to measure their cognitive level. If an athlete suffers a concussion, they repeat the test and athletic trainers and doctors will compare the scores to help gauge whether the athlete is ready to return to play. The computerized test uses words, shapes, colors and patterns to measure symptoms, reaction times and processing speed.

Each parent/guardian will need to complete the permission form to allow their child to participate in this free baseline test.

I _____ DO give _____ DO NOT give permission for my child, _____

to have a baseline ImPACT (Immediate Post-concussion Assessment and Cognitive Testing). I understand that my child may need to be tested more than once, depending on the results of the test, as compared to my child's baseline test, which is on file at Dysart High School. I understand there is no charge for the testing.

_____ Shadow Ridge High School may release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to my child's primary care physician, neurologist, or other treating physician, as indicated below. I understand that general information about the test data may be provided to my child's guidance counselor and teachers for the purpose of providing temporary academic modifications, if necessary.

Please print name of parent/guardian _____ Date _____

Signature of parent/guardian _____

Please print the following information:

Name of doctor: _____ Phone number: _____

Student's home address: _____

Parent/guardian preferred phone numbers: _____