ST. JOSEPH
SCHOOL DISTRICT

PARENTAL CONSENT FORM

I consent to have my son/daughter_____ participate in the IMPACT Concussion program.

I understand it is requirement for athletic participation and consists of a computerized Pre-test to establish baseline values. These values will only be used for comparisons if your son/daughter is referred to the IMPACT Program following a possible concussion.

All test scores are stored in a national data base and are completely confidential.

Please bring this signed Consent Form the day of the Pre-test. You can **not** be tested without the signed Consent Form.

Primary Care Physician _____

Parent/Legal Guardian signature_____
Date_____

High School _____

Student Date of Birth _____