Consent for Cognitive Testing and Release of Information

I give my permission for (name of child) _____ to complete baseline ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) testing administered by the Athletic Training Staff for Butler Area School District. In the event of an injury requiring post-concussion ImPACT testing, 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 remain on file at BHS. I understand there is no charge for the testing.

Butler Area School District may release the ImPACT results to my child's primary care physician, neurologist, or other treating physician, with my consent, by signing below.

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.

By signing below, I agree to participate in the ImPACT Concussion Management Program.

Printed Name of Athlete _____

Sport (s) _____

_____ _____

Signature of Athlete Date

_____ _____

Signature of Parent / Guardian Date