

## **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 agree to participate in the ImPACT Concussion Management Program.

Printed Name of Athlete	
the interest of the information gather <b>froq</b> o be each realth professionals to determine when return-	a concussion is suspected, the athlete will be required to require to the solution of the suspected to the suspected with your family doctor. The test data will enable the play is appropriate and safe for the injured athlete. If an epromptly contacted with all the details.
Signature of Athlete	on sure surbecom gainer TDA9mI set in it series or detween accompany of the accompany of th
egarding this program please feel free to contact	ppropriate signatures. If you have any further questions re- me and slobs@hackensackschools.org. incerely,
Signature of Parent	Sanielle Sloba, LAT
Athletes Home Room Teacher	Gym Class Period
Current Grade	