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 _____

SCHOOL ID # _____

SPORT _____

_____ _____

Signature of Athlete Date

_____ _____

Signature of Parent Date

Athletes will complete their baseline testing by appointment in the Coffman High School computer labs under direct supervision by the athletic trainers or their coaches.

Return To:

Coffman Athlete Health Care
6780 Coffman Rd
Dublin, Ohio 43017