Dear Parent/Guardian,

Beginning this fall, **St. Monica Catholic School** will be performing ImPACT testing on select athletes. The ImPACT (Immediate Post-Concussion Assessment and Cognitive Testing) was created as a screening tool to assist sports medicine professionals in evaluating athletes after a suspected concussion. Medical professionals who most frequently evaluate and treat sports medicine injuries are Orthopaedic surgeons, pediatricians, family medicine practitioners, although a broad range of specialists may also see the concussed athlete following their injury. In addition, Certified Athletic Trainers often play a crucial role in evaluation and treatment of the concussed athlete and are often involved in the baseline screening of the athlete.

ImPACT was not designed to take the place of regular medical care and should not be used without proper oversight. ImPACT should never be used as a "stand alone" instrument to make return to play decisions and the test results should always be placed within the context of the overall medical care of the athlete.

It is also important to emphasize that ImPACT is not a substitute for neuropsychological testing, which can only be completed by an appropriately trained and licensed Neuropsychologist. Neuropsychologists can play an important role in the evaluation of athletes who have experienced a concussion but are not usually involved in the acute management of the athlete. Neuropsychological testing can be particularly useful in treating athletes who have prolonged or complicated recoveries, or who have academic issues following injury.

By signing below, you give permission for your son or daughter to have a baseline ImPACT (Immediate Post-Concussion Assessment and Cognitive Testing) administered at **St. Monica Catholic School**. This baseline test will be on file at **St. Monica Catholic School**. There is no charge for the testing.

St. Monica Catholic 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 purposes of providing temporary academic modifications, if necessary. This information may be sent electronically via text or e-mail.

Name of Parent or Guardian: _____

Signature of Parent or Guardian: _____ Date:_____

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of Doctor: _____

Name of Practice or Group: _____

Phone Number: _____

Student's Name: _____

Student's Grade: _____

Student's Home Address:_____

Parent or guardian phone numbers (please indicate preferred contact number & time if necessary):

Home: _____ Work:_____ Cell:_____