**Traumatic Brain Injury**

**You must bring this signed form to the screening.**

**Screening Permission and Waiver**

**I. Voluntary Participation**

I, the undersigned, (*Please check one*) **□**Gives Permission,**□** Does NOT give permission for my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_, to voluntarily participate in the Traumatic Brain Injury (TBI) Prevention Screening for which my child will have provided a medical history form, will receive Magnetic Resonance Imaging (MRI), Magnetic Resonance Spectroscopy (MRS), and Diffusion Tensor Imaging (DTI) exams. The undersigned acknowledges and agrees that participation in the TBI Screening is completely voluntary and that it is the undersigned’s decision to have my child participate in this TBI Screening. HillMRI is a safe, noninvasive test that creates detailed pictures of your organs and tissues. "Noninvasive" means that no surgery is done and no instruments are inserted into your body. MRI uses radio waves, magnets, and a computer to create pictures of your organs and tissues. Magnetic Resonance Spectroscopy MRS is a series of noninvasive diagnostic tests that are added to the MRI scan to measure biochemical changes in the brain. MRS produces a profile of brain chemistry, and can compare the chemical composition in normal brain tissue and abnormal brain tissue. DTI is also added to the MRI scan and is used to show whether there is tissue destruction in the brain’s white matter, as a result from injury.

**□** I will accompany my child to the exam

**□** I am given permission to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to accompany my child to the exam.

**II. Assumption Of The Risk, Release And Waiver**

This information provided on the accompanying forms is, to the best of my knowledge, complete and correct. I understand that a finding of low risk from the screening being performed is not a guarantee of good health and that participation in this program cannot substitute for a consultation with a physician or other medical professional for any medical or health related conditions or for regular physical examinations.

I understand and acknowledge that information received from this screening is to be considered preliminary only and does not constitute a diagnosis of my child’s health or physical condition. This screening is not intended to replace regular checkups with my child’s physician. I further understand and acknowledge that I or another parent/guardian should discuss any abnormal results with my child’s personal physician as soon as possible. I or another parent/guardian should ensure that any abnormal results from the Cardiac Screening are confirmed by a physician before any diagnosis or treatment is considered.

I acknowledge that I am voluntarily allowing my child to participate in the Cardiac Screening and that it is my choice to have my child participate in the testing. I understand that Huntington Medical Research Institutes Magnetic Resonance Spectroscopy (HMRI MRS) Facility or my child’s school will formally inform the parent/guardian if there are any irregular or abnormal results of screening.

Parent’s/Guardian’s Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*All medical information obtained through my child’s participation in this program will be kept confidential and will not be used or retained by the school district. HMRI MRS may receive, use, and share your child’s Protected Health Information with other researchers, or as required by law, including with representatives of government agencies and others who are required to watch over the conduct of medical research. Your child’s name and other information that could be used to identify him/her will be removed.*

**The undersigned represent that they have carefully read and fully understand each and every term, condition, and paragraph of the provisions contained in this document.**

SCREENING DATE STUDENT’S NAME (PRINT) DATE OF BIRTH PLEASE INDICATE STUDENT’S SCHOOL

PARENT/GUARDIAN NAME (PRINT) PARENT/GUARDIAN SIGNATURE

HOME ADDRESS CITY STATE ZIP CODE

TELEPHONE NUMBER ALTERNATE/CELL NUMBER

PEDIATRICIAN OR PRIMARY CARE PHYSICIAN TELEPHONE NUMBER



**Huntington Medical Research Institutes Magnetic Resonance Spectroscopy Facility**

**10 Pico, Pasadena CA 91105 (626) 397-5840**