CONSENT FORM FOR ImPACT TESTING

I,_(Name of Parent/Guardian or Student Age 18 and over) _____ hereby consent to the administration of ImPACT testing for participation in athletics in the Bronxville Union Free School District ("District"). I understand that the ImPACT testing provides baseline neurocognitive testing on student athletes and will provide significant data for return to competition decisions. This baseline data, along with physical examination, and/or further diagnostic testing, will help determine, as one measure, when it is safe for a student to return to competition, after a concussion. (Please refer to Board Policy Part VIII: Pupils; Article XXVIII: Concussion Management and its implementing Regulation "Procedures for the Implementation of the Concussion Management Policy", the description of ImPACT testing at http://www.impacttest.com and the District's website: http://www.edline.net/pages/bxv.)

I understand that a concussion is a mild traumatic brain injury. Concussion occurs when normal brain functioning is disrupted by a blow or jolt to the head or body. Recovery from concussion will vary. Avoiding re-injury and over-exertion until fully recovered are the cornerstones of proper concussion management. I also understand that if my child sustains a concussion or head injury at a time other then when engaged in a school-sponsored activity, I must report the condition to the School Health Office.

I understand that ImPACT test results, written or otherwise, shall not be used for any purpose other than testing for cognitive functioning after symptoms of a concussion. I understand that the District will share ImPACT results with members of the Concussion Management Team ("CMT") in order to evaluate and manage student concussions for participation in District athletics but shall not otherwise release this information without my consent.

I have fully reviewed Board of Education Policy on Concussion Management (Part VIII: Pupils; Article XXVIII: Concussion Management) and the Guidelines and Protocols appended thereto, and understand that, among other things, no student shall return to school or play while experiencing symptoms consistent with those of a head injury and that no student shall resume athletic activity until he/she has been symptom free for not less than twenty-four (24) hours.

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Student Name and Age: _____ Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Student Signature (If 18 or Older):_____