Confirmation of Understanding of
Limited Scope and Purpose of the baseline ImPACT testing

I ____ am aware that my child/ward, ____________________________________, will undergo ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) administered at his/her school or a Methodist Hospital Facility under the direction of the athletic training staff and/or staff members from The Methodist Neurological Institute Concussion Center.

By signing this form, I am confirming my understanding of the following:

- I understand that this is **NOT** a comprehensive or diagnostic exam and should not take the place of routine medical care;

- I understand that this is a **baseline study only**, the results of which will be stored in a HIPPA secure database and may be accessed in future in the event child/ward presents for treatment;

- I understand that my child may need additional testing and I further understand that **it is my sole responsibility to obtain such additional testing or medical care**; I understand that if it is determined that my child should need additional treatment I will be notified of any such recommendation via mail, e-mail or telephone using the following contact information:

  E-MAIL ADDRESS ____

  CONTACT NUMBER ____

  STREET ADDRESS ____

  CITY, STATE ____

  ZIP CODE ______________________

- I realize that the results may be reviewed by the Methodist Concussion Center for validation.
- I understand that I can sign a release form to have the baseline results sent to myself or a medical provider of my choice.

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Parent/Guardian's Signature Date