Bristol Hospital
everyday extraordinary

Lewis S. Mills Athletics

CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION

Dear Parent/Guardian,

Lewis S. Mills High School utilizes an innovative program for our student-athletes to assist in the management of head injuries. The program is called ImPACT (Immediate Post Concussion Assessment and Cognitive Testing) and it is a computerized exam that the athlete takes prior to the season and if the athlete is believed to have suffered a head injury they re-take the exam to help determine a.) The extent of the injury b.) The location of the injury and c.) When the injury has healed.

I wish to stress that there is no invasive work being done with this program. This gives us the best available information in preventing brain damage that can occur with multiple concussions. The Lewis Mills administration, coaching, and athletic training staffs are trying to keep your child's health and safety at the forefront of the High School athletic experience. If you object to your child participating in this program, we ask that you please sign and return the opt-out form below to the Athletic Department.

Sincerely,

David Francalangia – Director of Athletics at Lewis Mills High School

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I give my permission for _____ (name of child)

Child's Date of Birth _____

To have pre- and post-concussion ImPACT© (Immediate Post-concussion Assessment and Cognitive Testing) testing administered at Lewis S. Mills High School. I understand that my child may need to be tested more than once, after comparing the post-concussion test results with my child's original baseline test. I am aware that there is no charge for this testing.

Lewis S. Mills High School may release the results of the ImPACT testing to my child's primary care physician, neurologist, or other attending physician indicated below.

I understand that some general test result data and information may be provided to my child's Guidance Counselor and Teachers, in order to develop temporary academic modifications.

Name of Parent or Guardian: _____

Signature of Parent of Guardian: _____

Date: _____

PLEASE PRINT THE FOLLOWING INFORMATION

Physician/Pediatrician's Name: _____

Physician's Practice or Group Name: _____

Physician's Phone Number: _____
Student's Home Address: _____

Parents' or Guardians' Contact Info (please indicate preferred contact number or time)
_____(H)_____(W) _____(Cell)

OPT-OUT SLIP

To Opt-Out from use of the Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT)

I have read the above information and prefer that my Child DOES NOT RECEIVE an ImPACT Baseline Test. In addition, I DO NOT WANT post injury re-testing to occur for my child.

Printed Name of Athlete_____ Sport _____

Signature of Athlete _____ Date _____

Signature of Parent _____ Date _____