Texas Health Sports Medicine offers *ImPACT* testing. 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. Certified Athletic Trainers 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.

I give consent to Texas Health Sports Medicine to administer the ***ImPACT*** baseline test for my child and allow them to release the ***ImPACT*** (Immediate Post-concussion Assessment and Cognitive Testing) Passport ID upon request to my child's primary care physician, neurologist, or other treating physician. To access a Texas Health Sports Medicine physician who is certified in using the ***ImPACT*** test, refer to www.texashealth.org/sportsmedicine and go to the "Sports Concussion" tab. This baseline test will be on file at Texas Health Sports Medicine.

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 Child: _____ Date of Birth: _____

School/Club: _____ Sport: _____

Name of Parent or Guardian: _____

Signature of Parent or Guardian: _____ Date: _____

Contact Phone #:_____ E-mail:_____

City: _____ Zip: _____

Primary Care Physician: _____ Contact #:_____