CONSENT FOR TREATMENT

I request that my son/daughter participate in Concussion Management baseline testing "Concussion Vital Signs."

I understand this testing is provided through Boulder Center for Sports Medicine (BCSM).

All records are recorded and maintained through BCSM and can be used as one indicator in determining return to play after having a concussion or concussion like symptoms.

Student Name: (print) _____

Parent Name: (print) _____

Parent Signature: _____ Date: _____