By completing the cognitive and balance concussion testing, I understand that no guarantee or assurance has been made that my child will not suffer a concussion. The testing conducted by Peak Performance Physical Therapy is performed to assist the doctor to make a better informed, safer decision to return my child to competition following a suspected concussion.

I also understand that a Medical Doctor **must** make the final decision and medically clear my child in order for him/her to return to athletic participation following a suspected concussion.

Any information obtained from baseline concussion testing is confidential and can only be accessed by those directly involved in the treatment and management of the individual athlete.

I have read and fully understand this consent form. I understand that I should not sign this form until all of my questions have been explained or answered to my satisfaction.

With my signature, I hereby consent to allow Peak Performance Physical Therapy to conduct baseline concussion testing on my child.

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Parent/Guardian Signature Date Physical Therapist Signature Date