UC San Diego Health

Free Pre-Participation Sports Exam for San Diego Unified Student Athletes

The screening will include all elements required to participate in sports for the 2018–19 school year, as well as optional concussion baseline testing and sports health and wellness educational presentations.

Check-In Times:

8 a.m.	Football (last names starting with A-M)
8:30 a.m.	Football (last names starting with N-Z)
9 a.m.	Badminton, baseball, basketball, cheerleading
9:30 a.m.	Cross country, field hockey, golf, lacrosse
10 a.m.	Soccer, softball
10:30 a.m.	Swimming & diving, tennis, track & field, volleyball
11 a.m.	Water polo, wrestling

What to Bring

- School identification card
- Completed San Diego Unified health history form — ***must be signed by parent***
- Completed ImPACT baseline consent form (for optional concussion baseline testing) — ***must be signed by parent***

The screening is free only for CIF-sanctioned sports participants. For more information, please contact your high school athletic trainer or athletic director.

Event Details

When: Saturday, June 9, 2018
Time: 8 a.m. to 11 a.m.

Hoover High School
4474 El Cajon Blvd.
San Diego, CA 92115

Come dressed in athletic clothing and enter through the main office. Volunteers will direct you to the auditorium for check-in.

***Parents**: Please visit our wellness programs and screening exhibits while waiting for your child to complete the screening. If you are unable to attend, sign and complete forms and send with your child.*

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CONSENT FOR BASELINE COGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for (name of child) _____,
born (date of birth) _____, to have a baseline ImPACT® (Immediate Post-Concussion Assessment and Cognitive Testing) test administered by UCSD Health. I understand that my child may need to be tested more than once, depending upon the results of the test. I understand there is no charge for the testing.

UCSD Health may release the ImPACT test results to my child's primary care physician, neurologist, other treating physician, or any licensed healthcare professional as indicated below.

I understand that general information about the test data may be provided to my child's guidance counselor, school nurse, principal and teachers, for the purposes of providing temporary academic modifications, if necessary.

Signature of parent/guardian _____

Name of parent/guardian _____

Date _____

Please print the following information:

Physician/licensed healthcare professional _____

Practice or group name _____

Phone number _____

Student's home address (street address, city/state/zip)

_____

Parent or guardian phone numbers:

Home _____

Work _____

Mobile _____

Preferred contact number: Home Work Mobile

Preferred time to call (if necessary): _____ am/pm