



ConcussionManagement.com

<insert your school logo here>

# Consent Form

## GROUP 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 at <insert school/organization name>. 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.

<insert school/organization name> 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 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 \_\_\_\_\_

Preferred contact number: Home Work Mobile

Work \_\_\_\_\_

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

Mobile \_\_\_\_\_