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 at Parkside Middle School. I understand that my child may need to be tested more than once, depending upon the results of the test. I understand I will be responsible for the associated $10 fee for this testing.

Parkside Middle School 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