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 Nemaha Central Junior/High School. 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.

Nemaha Central Junior/High 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

Work

Mobile

Preferred contact number: Home Work Mobile

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