CONSENT FOR COGNITIVE TESTING

&

RELEASE OF ImPACT INFORMATION

I give permission for (name of child)_____

Date of Birth:_____

to have a baseline and post-concussion ImPACT (Immediate Post-Concussion Assessment and Cognitive Testing) administered at Maur Hill Mount Academy by the Atchison Hospital. I understand that my child will be administered a baseline test prior to participation in sports. I also acknowledge that if the test is not valid they will be asked to repeat the baseline testing.

I further understand that if during the course of the season my child sustains a head injury (concussion) or is suspected of sustaining a head injury (concussion) they will be administered the post-concussion ImPACT test. I understand that my child may need to be tested more than once, depending upon the results of the test, as compared to my child's baseline test, which is on file at Atchison Hospital. I understand that there is no charge for the testing.

Maur Hill Mount Academy may release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to my child's primary care physician listed below, neurologist, or other treating physician as indicated below.

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

Name of Parent or Guardian:_____

Signature of Parent or Guardian:_____

Date:_____

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of Doctor:_____

Name of Practice or Group:_____

Phone Number:_____

Student's Home Address:_____

_____

Parent or Guardian Phone Numbers: (please indicate preferred contact number and time if necessary):

Home:_____ Work:_____

Cell:_____