



®



## 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 Immanuel Christian 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.

Immanuel Christian 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 School Nurse, coaches,  
and teachers, for the purposes of providing temporary academic or athletic 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 \_\_\_\_\_