Spring Valley Middle/High School
Baseline Concussion Testing
2012/13

CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for (name of child) _____

(child's date of birth) _____

to have a post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) administered at Spring Valley High School. 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 Spring Valley High School. I understand there is no charge for the testing.

Spring Valley High School may release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to my child's primary care physician, neurologist, or other treating physician, 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.

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 & time if necessary):

_____ (H) _____ (W)

_____ (cell)