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## Consent Form

For use of the Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT)

I have read the attached information. I understand its contents. I have been given an opportunity to ask questions and all questions have been answered to my satisfaction. I agree to participate in the ImPACT Concussion Management Program.

**Printed Name of Athlete** \_\_\_\_\_

**Sport** \_\_\_\_\_

\_\_\_\_\_  
Signature of Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date



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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 Sharpville Area School District. 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 Sharpville High School. I understand there is no charge for the testing.

Sharpville Area School District 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):

\_\_\_\_\_ (Home)

\_\_\_\_\_ (Work)

\_\_\_\_\_ (Cell)