CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION

Name of Child: _____

Childs date of birth: ____/____/_____

I give my permission for (name of child) _____ to have a baseline and, if necessary, a post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) test administered at Douglas County Hospital by the staff from Heartland Orthopedic Specialists Sports Medicine. 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 my child's school. I understand there is no charge for the testing.

My child's school and Heartland Orthopedic Specialists Sports Medicine 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)

HEARTLAND
Orthopedic Specialists
A Department of Douglas County Hospital
Sports Medicine