# 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 through Central Montana Medical Center. I understand that my child may need to be tested more than once, depending upon the results of the test.

Central Montana Medical Center 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 guidance counselor and teachers, for the purposes of providing temporary academic modifications, **only if necessary**, and **only upon prior parent approval.**

Signature of parent/guardian_____Date_____

Witness Name / Signature _____Date _____

**PLEASE PROVIDE THE FOLLOWING INFORMATION:**

Physician/licensed healthcare professional _____

Phone number _____

**Parent or Guardian Contact Information:**

Name_____ Contact Phone Number: _____

**Student's Home Address** (street address, city/state/zip)

_____

☐ I do NOT want any information released to the following:

- ☐ Healthcare Professionals
- ☐ School Guidance Counselors
- ☐ School Staff
- ☐ Other: _____