ImPACT APPLICATIONS, INC.
ConcussionManagement.com

Iowa Specialty Hospital
Specializing in You

Consent Form

GROUP 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 by Clarion-Goldfield-Dows Community School District or Iowa Specialty Hospital. 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.

Clarion-Goldfield-Dows Community School District or Iowa Specialty Hospital 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, 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 _____

Work _____

Mobile _____

Preferred contact number: Home Work Mobile

Preferred time to call (if necessary): _____ am/pm