CONSENT TO TREAT FOR COMPUTERIZED NEUROCOGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for (name of child) _____

(date of birth) _____

To be tested using ImPACT (Immediate Post-concussion Assessment and Cognitive Testing), a concussion assessment tool, administered by Active Physical Therapy. I understand that my child will be baseline tested and if a concussion occurs, may be retested using ImPACT and functional testing following the concussion. Post-concussion results will then be compared to my child's baseline test, which will be on file on a secure server with ImPACT, in order to determine safe return to play.

I give permission to Active Physical Therapy to release ImPACT testing results to an ImPACT trained physician to read the testing results of my student-athlete. I understand that post-concussion test results may be provided to my child's guidance counselor and teachers for providing temporary academic modifications until the symptoms of the concussion have subsided.

Name of parent or guardian: _____

Signature of parent or guardian: _____

Date: _____

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of Primary Care Physician: _____

Parent/guardian phone numbers (please indicate preferred contact number and time if necessary):

Home #: _____

Work #: _____

Cell #: _____