BISHOP FEEHAN HIGH SCHOOL

ATHLETICS

ImPACT TESTING

CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION

Student Name: _____Grade_____

Date of Birth _____

Fall Sport _____
Winter Sport _____
Spring Sport _____

I give my permission for (name of child) _____ to have a post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) program administered at Bishop Feehan High School. 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 Bishop Feehan High School. I understand there is no charge for the testing.

Bishop Feehan High School 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/guardian: _____
(please print)

Signature of parent/guardian: _____

Date: _____

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of doctor: _____

Name of practice or group: _____

Phone number: _____

STUDENT'S HOME ADDRESS: _____

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

_____(H) _____ (W)

_____(cell)