****

**CONSENT FOR BASELINE COGNITIVE and RELEASE OF INFORMATION**

I give my permission for (PRINT name of child) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

born (date of birth) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to have a baseline ImPACT® (Immediate Post-Concussion Assessment and Cognitive Testing) test administered at Prophetstown High School by Hammond-Henry Hospital Staff. 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.

Prophetstown or Erie High School/Hammond-Henry Hospital may release the ImPACT test results to my child’s primary care physician, neurologist, other treating physician, or the 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. HIPAA compliance is in effect as this information is considered Personal Medical Information (PMI).

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:

Name

Home Preferred contact number: Home Work Mobile

Work Preferred time to call (if necessary): \_\_\_\_\_\_\_\_\_\_ am/pm

Mobile