CLARKSVILLE HIGH SCHOOL
ATHLETIC DEPARTMENT

CONSENT FOR COGNITIVE TESTING AND RELEASE OF INFORMATION

I give my permission for (name of child) ___________________________________

(child's date of birth) ________________________________

to have a post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) administered at Clarksville 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 CHS. I understand there is no charge for the testing.

Clarksville High School may release ImPACT 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.

____
Parent/Guardian Name (Print)

____
Parent/Guardian Signature

____
Date

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of Doctor: _________________________________

Name of Practice or Group: ________________________