Florida Hospital

SPORTS CONCUSSION PROGRAM

407-303-8012

CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION

I give permission and authorize (Name of School) _____ and/or the Florida Hospital Sports Concussion Program to test my child using *ImPACT®* (Immediate Post-concussion Assessment and Cognitive Testing). *ImPACT®* testing is part of a concussion program that has been incorporated as part of the school's athletic program to provide the highest level of care for head injuries to an athlete and assist in determining when it is safe for the athlete to return to athletic participation.

I understand that my child will receive a baseline test prior to participating in school sports programs, which may need to be repeated depending upon preliminary results of the initial test. The baseline test results will be on file in the Florida Hospital Sports Concussion Program and accessible by my school's Athletic Trainer and will be used for comparison purposes only in the event of an injury. In the event of an injury, I understand that one or more additional *ImPACT®* tests may be administered, and the results compared to the baseline test results by a member of the Florida Hospital Sports Concussion Program and shared with me. I release and hold harmless (Name of School) _____to release the results of the *ImPACT®* test(s) of my child to the Florida Hospital Sports Concussion Program, which may consist of neuropsychologists, primary care physicians, neuro-surgeons, athletic trainers and other treating physicians. I understand that there is no charge for the baseline *ImPACT®* testing.

I may revoke my consent at any time by submitting a revocation request in writing to my child's school.

I understand that this consent for testing and authorization for release of my child's information will expire at the end of each school year.

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE

I give my permission for (Name of Child) _____

(Child's Date of Birth) _____ to have a baseline and post-injury *ImPACT®* test administered at a location designated by my child's school. In addition to the member(s) of the Florida Hospital Sports Concussion Program and the school's Athletic Trainer, (Name of School) _____ may release the *ImPACT®* results to my child's primary care physician, neurologist, or other treating physician, as indicated below.

Name of parent or guardian: _____

Signature of parent or guardian: _____Date: _____

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of primary care physician: _____

Name of practice or group: _____

Phone number: _____

Student's home address: _____

Parent or guardian phone numbers (please indicate preferred contact number & time if necessary):