UC San Diego Health
Sports Medicine

CONSENT FOR BASELINE COGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for (name of child) ____,
born (date of birth) ___________________, to have a baseline ImPACT® (Immediate Post-Concussion Assessment and Cognitive Testing) test administered by UCSD Health. 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.

UCSD Health may release the ImPACT test results to my child's primary care physician, neurologist, other treating physician, or any licensed healthcare professional as indicated below.

I understand that general information about the test data may be provided to my child's guidance counselor, school nurse, principal and teachers, for the purposes of providing temporary academic modifications, if necessary.

Signature of parent/guardian ____

Name of parent/guardian ____

Date ____________________________

Please <u>print</u> 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:

Home ________________________________ Preferred contact number: Home Work Mobile

Work ________________________________ Preferred time to call (if necessary): __________ am/pm

Mobile ________________________________