Oregon Episcopal School

ALWAYS OPEN

CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for (name of student) _____, birthdate _____, to be tested as part of the ImPACT program administered at Oregon Episcopal School. This will include a baseline neurocognitive test, and if a concussion injury occurs, a post neurocognitive test. I understand there is no charge for the testing. Oregon Episcopal 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. Parents will be notified if information is released to physicians. I understand that in the case of a concussion injury, general information about the test data may be provided to my child's grade level dean and teachers, for the purposes of providing temporary academic modifications, if necessary.

Name of parent or guardian: _____

Signature of parent or guardian: _____

Date: _____

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of doctor: _____

Name of practice or group: _____

Phone number: _____