Livingston High School

Department of Athletics

Patrick J. Genova
Director of Athletics

Paul Ehrenfeld ATC
Athletic Trainer

CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for my child _____, whose date of birth is _____, to be initially tested using the **ImPACT** (**I**mmediate **P**ost-Concussion **A**ssessment and **C**ognitive **T**esting) **Concussion Assessment Program** at Livingston High School. This online computer test will be conducted by the LHS athletic trainer in the LHS computer lab prior to and /or during the season of athletic team participation.

It is understood that this initial test will establish a baseline score for my child and the results of this test are valid for two years. During that time span, there will be no need to retest unless there is suspicion of a concussion taking place during participation in the LHS athletic program. If the possibility of a concussion exists, I give permission for my child to be retested in the same manner as described above.

I understand that there will be **no charge** for this testing.

I also give Livingston High School permission to release the ImPACT results, if requested by the parent, to my child's primary care physician, neurologist, or other treating physician as indicated below.

Physician's to whom results may be released to (please print)

Name of Doctor: _____ **Name of Doctor:** _____

Phone Number: _____ Phone Number: _____

Student's Home Address _____

Name of Parent or Guardian (print): _____

Signature of Parent or Guardian: _____

Date: _____

Parent or Guardian Phone Numbers

(H) _____(C) _____ (W) _____

Child's Sport _____