

Fall Sport \_\_\_\_\_ Winter Sport \_\_\_\_\_

Spring Sport \_\_\_\_\_

## CONSENT FOR ImPACT TESTING and RELEASE OF INFORMATION

I give my permission for (name of child) \_\_\_\_\_

(child's date of birth) \_\_\_\_\_

to have a pre-injury and (if needed) a post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) administered at Quince Orchard 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 or the population normal (if no baseline is necessary). There may be additional charges for the follow-up testing, depending on the number of post-injury tests required.

Quince Orchard High School will share/release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to my child's primary care physician, neurologist, or other treating physician, and to Christopher Raffo, MD, the team physician for Quince Orchard High School.

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.

Name of parent or guardian: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

### PLEASE PRINT THE FOLLOWING INFORMATION:

Name of Pediatrician/Family doctor: \_\_\_\_\_

Primary Physician Medical Practice name: \_\_\_\_\_

Phone number of primary doctor: \_\_\_\_\_

Student's home address: \_\_\_\_\_

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

\_\_\_\_\_ (H) \_\_\_\_\_ (W)

\_\_\_\_\_ (cell)

### PLEASE READ THE ImPACT HANDOUT.

**PLEASE ATTACH A FIVE DOLLAR (\$5) DONATION (CHECK OR CASH.)**

**CHECKS SHOULD BE MADE PAYABLE TO "Maryland Orthopedic Specialists"**

Paid: \_\_\_\_\_

Date \_\_\_\_\_

Cash \_\_\_\_\_ Waived: \_\_\_\_\_

Check # \_\_\_\_\_