Middle Township School District

Consent for Cognitive Testing and Release of Information

I give my permission for (name of child) _____

(child's date of birth) _____ to undergo Baseline ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) and a Post Concussion ImPACT test, as necessary, administered at Middle Township High/Middle 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, which is on file at MTHS/MTMS. I understand there is no charge for testing.

Middle Township High/Middle 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.

I understand that the 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/Guardian: _____

Signature of Parent/Guardian: _____

Parent/Guardian preferred contact number: _____

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of Doctor: _____

Name of Practice or Group: _____

Phone Number of Doctor's Practice: _____