



## Consent Form

---

### BASELINE COGNITIVE TESTING AND RELEASE OF INFORMATION

I give my permission for (name of child) \_\_\_\_\_,  
born (date of birth) \_\_\_\_\_, to have a baseline ImPACT<sup>®</sup> (Immediate Post-Concussion Assessment and  
Cognitive Testing) test administered at Cherokee Community Schools. 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.

Cherokee Community Schools 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 and  
teachers, for the purposes of providing temporary academic modifications, if necessary.