Dubuque COMMUNITY SCHOOLS

CONSENT FOR COGNITIVE TESTING AND RELEASE OF INFORMATION

I give my permission for (NAME OF STUDENT) _____ (DATE OF BIRTH) _____

to have a baseline and if needed post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) administered at Senior High School. I understand that if my child sustains a concussion he/she may need to be tested more than once, depending upon the results of the test, as compared to my child's baseline test, which will be on file at Dubuque Senior High School. I understand there is no charge for the testing.

Senior High 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 general information about the test data may be provided to my child's guidance counselor and teachers, for the purposes of providing temporary academic modications, if necessary.

_____ _____

PARENT / GUARDIAN SIGNATURE DATE

STUDENT INFORMATION

ADDRESS:	CITY:	ZIP:

PARENT / GUARDIAN INFORMATION

PARENT / GUARDIAN NAME(S):		
HOME PHONE:	CELL PHONE:	WORK PHONE:
PLEASE INDICATE PREFERRED CONTACT NUMBER AND TIME (IF NECESSARY):		

DOCTOR INFORMATION

DOCTOR NAME:	PRACTICE / GROUP NAME:
PHONE:	

NOTE: If you wish to save data typed into this form, first save the file on your computer and re-open from your computer prior to typing.