CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for (name of child) _____

(child's date of birth) _____

to have a Baseline or Post-Concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) test administered at by Mankato Area Hockey Association (MAHA). I understand that a baseline test will be on file at MAHA. I also understand my child may need to be tested more than once, depending upon the results of the test, and will be compared to my child's baseline test. I understand there is no charge for the testing.

MAHA 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.

Name of parent or guardian: _____

Signature of parent or guardian: _____

Date: _____

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of doctor: _____

Name of practice or group: _____

Phone number: _____

Student's home address:_____

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

_____ (H) _____ (W)

_____ (cell)

10/2015