



CONSENT FOR BASELINE COGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for (name of child) _____,
born (date of birth) _____, to have a baseline ImPACT® (Immediate Post-Concussion Assessment
and Cognitive Testing) test administered at WRMS by St Lukes. 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.

St Lukes 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.

Signature of parent/guardian _____

Name of parent/guardian _____

Date _____

Please print the following information:

Physician/licensed healthcare professional _____

Practice or group name _____

Phone number _____

Student’s home address (street address, city/state/zip)

Parent or guardian phone numbers:

Home _____

Preferred contact number: Home Work Mobile

Work _____

Preferred time to call (if necessary): _____ am/pm

Mobile _____