North Attleboro High School Athletic Department

CONSENT FOR COGNITIVE TESTING
And RELEASE OF INFORMATION

Student's Name	Sex	Date of Birth	Grade /YOG
School		Sport(s)	
Home Address			Telephone

I give my permission for this student athlete to have ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) administered at North Attleboro High 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 will be on file at NAHS.

I understand there is no charge for the testing. North Attleboro High School may release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to the school athletic trainer, 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 modifications, if necessary.

If you have any questions or concerns please call Jen Fitzpatrick-athletic trainer 508-962-9006 jfitzpatrick@naschools.net or Kurt Kummer –athletic director 508-643-2129 kurtkummer@naschools.net

Name of parent or guardian: ______________________________

Signature of parent or guardian: ______________________________ Date: __________

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of primary care physician: ______________________________

Name of practice or group: ______________________________

Phone number: ______________________________

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

__________________ (H) __________________ (W)__________________ (cell)

__________________ (H) __________________ (W)__________________ (cell)