



OFFICE OF THE COORDINATOR
Interscholastic Athletics
Student Relations
Collier County Public Schools
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ImpACT (Immediate Post-concussion Assessment and Cognitive Testing) Program

CONSENT FOR BASELINE AND POST INJURY COGNITIVE TESTING and RELEASE OF INFORMATION

I give permission for (name of child) _____

(Child's date of birth) _____

to undergo baseline ImpACT cognitive testing administered by Collier County Schools. This test is a non-invasive, computer-based test. All student test data is kept confidential, in compliance with HIPPA requirements.

If a head injury is suspected, my child may undergo post-concussion ImpACT testing. I understand that my child may need to be tested more than once, depending upon the results of the test, as compared to normative data or my child's baseline test data, which is kept on the file at the secure ImpACT website. The result(s) of these tests may be a factor in determining when/if my child will be permitted to resume active participation. Written clearance from a physician and normal progression through a series of steps administered by a Certified Athletic Trainer are also required before return to play is approved. I understand there is no charge for the testing.

Collier County Schools has permission to release ImpACT test 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 school counselor and teachers, for the purposes of providing temporary academic modifications, if necessary.

Print Name of parent or legal guardian: _____

Signature of parent or legal guardian: _____ Date: _____

PLEASE PRINT NAME OF DOCTOR(S) TO WHOM TEST DATA MAY BE RELEASED:

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):

(Home) _____ (Work) _____ (Cell) _____