Rockland Public Schools
Consent for Testing & Release of Information
For Management of Sports Related Concussion

Student's Name: _____ Date of Birth: _____

Student's Address: _____

I give permission for _____ to have a baseline ImPACT™ test administered at Rockland High School. Included in the ImPACT™ test procedure will be a Sports Related Concussion Survey. I understand there is no charge for this testing.

I agree to have a post concussion ImPACT™ test administered, if necessary, at Rockland High School. (Immediate Post Concussion Assessment/Questionnaire and Cognitive Testing)

I understand that my child may need to be tested more than once, depending on the results of the test (as compared to the baseline test which will be on file at Rockland High School.)

Rockland High School may release the ImPACT™ Testing results to my child's primary care physician, neurologist, or other treating physician as indicated below.

Name of Parent/Guardian (Print):		
Signature of Parent/Guardian	Date	
Home Phone	Work Phone	Cell Phone

Name of Student's Doctor	Doctor's Phone Number
Name of Practice or Medical Group	