more than health care ... life care

MOSAIC LIFE·CARE

myMosaicLifeCare.org

High School: _____

CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for (name of minor child) _____
(child's date of birth) _____

to have a baseline ImPACT® (Immediate Post-concussion Assessment and Cognitive Testing) administered as well as any post-concussion ImPACT® deemed reasonably necessary following an injury. 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 shall be kept on file at Heartland Regional Medical Center.

I acknowledge and agree that Heartland Regional Medical Center 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.

I further understand and agree 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.

I have read and understand the information contained in this consent form.

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

Home: _____ Work: _____ Cell: _____