CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for (name of child) _____

(child's date of birth) _____

to have pre and post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) administered at Franklin County 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 is on file at FCHS. I understand there is no charge for the baseline testing and that testing is required by Indiana State Law. I understand that failure to take all testing prior to participation will result in my child being disqualified from participation in the following activities:

- Athletics
- Band
- Choir
- Physical Education Class
- Intramural activities
- Homecoming activities
- Club Sports (Archery, FFA)

Franklin County High School may release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to a neurologist licensed by the State of Indiana in Sport Concussions, as well as, my child's primary care physician, or other treating physician, as indicated below.

I understand that Indiana State Law requires my child to be baseline tested, and following any incident that could potentially cause a concussion, my child must be evaluated by a physician licensed as a sport concussion specialist. I understand that information will be provided to me regarding those physicians licensed by the State of Indiana and failure to see one of those physicians, in a timely manner, will result
in my child being disqualified for sport participation for the remainder of the current school year. Failure to see a recognized physician will also result in the student being withheld from physical education, band, choir and intramural/club activities until such time as the student has seen and been released by a certified physician.

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.

Name of parent or guardian: _____

Signature of parent or guardian: _____

Date: _____

PLEASE PRINT THE FOLLOWING INFORMATION:

Student's home address:_____

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

_____ (H) _____ (W)_____ (cell)