LAKE PRESTON PUBLIC SCHOOL

Athletic Director ~ Mr. Jordan Solberg ~ (605) 847-4455

Consent Form

BASELINE COGNITIVE TESTING AND RELEASE OF INFORMATION

CHILD'S NAME: Last:_____ Middle Initial:_____ First:_____

SCHOOL District:_____

PARENT/GUARDIAN NAME (Primary Contact):_____

Preferred Phone Number: _____ **Second Phone Number:** _____

Email Address: _____

Address: _____

STREET ADDRESS CITY STATE ZIP CODE

CHILD'S PHONE (if different from parents): _____

CHILD'S birth date? Month: _____ Day: _____ Year: _____

CHILD'S year in school: (2023-24 school year) 6th 7th 8th 9th 10th 11th 12th

CHILD'S current age? _____ **Circle gender**: male female

I give my permission to complete baseline testing using the ImPACT® (Immediate Post-Concussion Assessment and Cognitive Testing) test administered at the Lake Preston School. I understand that my child may need to be tested more than once, depending upon the results of the test. I understand there is no charge for the testing.

The Lake Preston School District may release the ImPACT test results to my child's primary care physician, neurologist, other treating physician, or any licensed healthcare professional 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.

Signature of parent/guardian_____ **Date** _____

I **DO NOT** give my permission to complete baseline testing using the ImPACT® (Immediate Post-Concussion Assessment and Cognitive Testing) test administered at the Lake Preston School.

Signature of parent/guardian_____ **Date** _____