RIDGE HIGH SCHOOL
BERNARDS TOWNSHIP PUBLIC SCHOOL DISTRICT
DEPARTMENT OF HEALTH, PHYSICAL EDUCATION, AND ATHLETICS
268 South Finley Avenue
Basking Ridge, New Jersey 07920
Phone (908) 204-2585 ~ Fax (908) 204-1356

CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for (name of child) ___________________
to have a post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) administered at Ridge 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 RHS. I understand there is no charge for the testing.

Ridge High School 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 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.

Print name of parent or guardian:

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Signature of parent or guardian:

____

Date: ____

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of doctor: _____________________________________

Phone number: ____________________________________

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

_________________________ (H) ____________________________ (W)

_________________________ (cell)