



**CONSENT FOR BASELINE COGNITIVE TESTING and RELEASE OF INFORMATION**

I give my permission for (name of child) \_\_\_\_\_,  
born (date of birth) \_\_\_\_\_, to have a baseline ImPACT® (Immediate Post-Concussion Assessment and Cognitive Testing) test administered at (child’s school district) \_\_\_\_\_ by Pacific Sports Spa, LLC. I understand that my child may need to be tested more than once, depending upon the results of the test.

Pacific Sports Spa is authorized to 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 their consideration of whether or not to provide temporary academic modifications.

I have the authority to act on behalf of the above named child and will indemnify and hold Pacific Sports Spa harmless for all costs it may incur, including reasonable attorney fees, for any claim to the contrary and/or its acts pursuant to this Consent.

Signature of parent/guardian \_\_\_\_\_

Name of parent/guardian \_\_\_\_\_

Relationship to child \_\_\_\_\_

Date \_\_\_\_\_

**Please print the following information:**

Physician/licensed healthcare professional \_\_\_\_\_

Practice or group name \_\_\_\_\_

Phone number \_\_\_\_\_

Child’s home address (street address, city/state/zip)  
\_\_\_\_\_

Parent or guardian phone numbers:

Home \_\_\_\_\_

Preferred contact number: Home Work Mobile

Work \_\_\_\_\_

Preferred time to call (if necessary): \_\_\_\_\_am/pm

Mobile \_\_\_\_\_

Schedule online for Thursday, August 18<sup>th</sup>: (Or visit Pacific Sports Spa Facebook page for the link)

<https://www.secure-booker.com/PacificSportsSpaLLC/ClassSchedule/ClassSchedulre.aspx>