Sacramento Valley
PLAY IT SAFE
Concussion Care Consortium

"Concussion management is a team effort"

Consent Form

Date: _____

I give my permission for _____
NAME OF CHILD

to have a baseline ImPACT test (Immediate Post-concussion Assessment and Cognitive Testing) administered by the Sacramento Valley Play It Safe Concussion Care Consortium. The Consortium may release the ImPACT results to my child's primary care physician or other treating physician as indicated below. They may also release the results to the school's coach, athletic director or trainer, or other representative (i.e. designated concussion coordinator). The test data is stored on a secured server through the ImPACT company which can only be accessed using a valid login and password. This consent is only valid while participating in the current

_____ season through _____.
SPORT ORGANIZATION

Parent/Guardian: _____ _____
PLEASE PRINT SIGNATURE

☐ Testing declined

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of doctor: _____

Name of practice or group: _____

Phone number: _____ Fax number: _____

Student's home address: _____

City _____ State _____ Zip _____

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

(H) _____ (W) _____ (Cell) _____

☐ Check if it is ok to leave a message