MIS 5348
3/2015

OKALOOSA COUNTY SCHOOL DISTRICT
STUDENT INTERVENTION SERVICES
CONSENT FOR ImPACT NEUROCOGNITIVE TESTING AND RELEASE OF INFORMATION
FOR ATHLETIC PARTICIPATION IN OKALOOSA COUNTY

PLEASE CHECK AND COMPLETE SECTION "A" OR "B" AND SIGN AT THE BOTTOM

_____**Section A**

I give my permission for (name of child)_____
(Date of Birth)_____to take the ImPACT Neurocognitive baseline concussion test administered by the Okaloosa School District system through any of its designated employees and/or approved volunteers. I give permission for my child to provide all the information requested necessary to complete the test. I understand that my child may need to be tested more than once, depending on the validity of the testing results.

I also understand that the test results of the ImPACT Neurocognitive test may be released to my child's guidance counselor and teachers, including Principals, Athletic Coaches and trainers, and nurses for the purpose of providing temporary academic and athletic modifications if necessary for concussion management. I also consent to the release of the ImPACT testing results to any Medical Physician, who in the treatment of my concussed child, submits a request for release of medical records complaint to State and Federal guidelines.

I understand that I may revoke this consent forNeurocognitive testing at any time; however, I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality.

_____Section B

I **do not** give my permission for (name of child)_____
(Date of Birth)_____ to take the ImPACT Neurocognitive baseline concussion test administered by the Okaloosa School District system.

Parent(Guardian) Signature_____ Date_____

Student Signature_____ Date_____