



NEWTOWN HIGH SCHOOL
12 BERKSHIRE ROAD
SANDY HOOK, CT 06482
(203) 426-7651
FAX (203) 270-4896

NEWTOWN SUCCESS-ORIENTED SCHOOL MODEL



CONSENT FOR ImPact TESTING and RELEASE OF INFORMATION

I give my permission for (name of child) _____

(child's date of birth) _____

to have a post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) administered at Newtown 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 NHS. I understand there is no charge for the testing.

Newtown 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 school administration for academic reasons only.

Name of parent or guardian: _____

Signature of parent or guardian: _____

Date: _____

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of doctor: _____

Name of practice or group: _____

Phone number: _____

Student's home address: _____

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

_____ (H) _____ (W)

_____ (cell)