OSF
SAINT LUKE
MEDICAL CENTER

CONSENT FOR IMPACT & SCAT3 CONCUSSION TESTING and RELEASE OF INFORMATION

I give my permission for

(Child's Name) _____ DOB: _____

to have a pre and post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) & SCAT3 (Sport Concussion Assessment Tool) administered by OSF Saint Luke Medical Center Rehabilitation Services Staff. Testing may take place either at my child's school or at OSF Saint Luke Medical Center. I understand that my child may need to be tested more than once, depending upon the results of the test, which will be on file at OSF Saint Luke Medical Center. I understand this test is free to all KHS athletes.

OSF may release the ImPACT & SCAT3 results to my child's primary care physician and/or other treating physician, for personal safety if a concussion is suspected.

I understand that general information about the test data may be provided to my child's athletic director or coach for the purposes of providing temporary practice/game modifications, if necessary.

Name of Parent or Guardian: _____

Signature of Parent or Guardian: _____

Date: _____

PLEASE PRINT THE FOLLOWING INFORMATION:

Physician/Medical Provider: _____

Office Phone Number: _____

Student's Home Address: _____

_____

Parent or Guardian Phone Numbers (please indicate preferred contact number & time if necessary):

Home: _____ Work: _____

Cell: _____