



**CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION
(ImPACT® Test Form)**

ImPACT™ baseline testing is required prior to the participation of any student in any GUSD athletic activity. Parents must sign and submit this form prior to testing being administered to any student by GUSD staff.

SCHOOL NAME: Gilroy High School

Name of Student:	_____
Student Date of Birth:	_____
Student ID Number:	_____

I give my permission for my child listed above to have a baseline ImPACT® test and if necessary post-concussion ImPACT® (Immediate Post-concussion Assessment and Cognitive Testing) administered at **Gilroy Unified School District**. 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 **Gilroy Unified School District**. I understand there is no charge for the testing.

Gilroy Unified School District may release the ImPACT® (Immediate Post-concussion Assessment and Cognitive Testing) results to Gilroy Unified School District Sports Medicine Team Physicians and Physician Assistants, my child's primary care physician, neurologist, or other treating physician, as necessary.

I understand that general information about the test data may be provided to my child's guidance counselor and teachers, for the purposes of providing temporary academic modifications, if necessary.

Print Name of parent or guardian: _____

Signature of parent or guardian: _____

Date: _____

Administration Use Only:

Date of Baseline: _____

Class of: _____