Park Hill School District

Consent Form BASELINE TESTING AND RELEASE OF INFORMATION

I, _____, give my permission for my child,
Print Full Name of Parent or Guardian

_____, to complete pre-concussion baseline
Name of Child
testing with a qualified Park Hill School District staff member.

I understand my child may need to be tested more than once, depending on the results of the test. I understand there is no charge for the testing.

Park Hill School District utilizes a concussion management system called Sway. An administered concussion baseline test will combine objective balance measures and cognitive measures used by healthcare professionals in performing accurate and informed evaluations. In case of an injury or when treating an injury, Park Hill School District may release my child's result to my child's primary care physician, neurologist, other treating physician or any licensed healthcare professional involved in treating related conditions.

In the event of a concussion or other injury, I understand that, to the extent necessary, information regarding my child's condition may be provided to my child's school nurse, counselor and/or teachers for the purposes of providing temporary academic modifications.

_____ _____
Signature of Parent or Guardian Date