CENTEGRA HEALTH SYSTEM ◆ Wellness ◆ 815-759-4342 ◆ FAX: 815.206.2830

Centegra Health System

	Johnsburg High School
Legal Name	First: ________________ MI: ______________ Last:_________________
Address	
City/Zip	
Phone	
E-Mail Address of Parent	
Age, Date of Birth, Gender and Height	Age:________ Date of Birth:___________ Gender:________ Height:_________
LEAVE THIS FORM **following screening (PLEASE DO NOT TAKE WITH YOU)**	Participant Sport:___________________________ **CENTEGRA INFORMED CONSENT FOR PARTICIPATION IN Concussion Screening:** I give permission for:______________________to receive ImPACT (Baseline Cognitive Testing) by Centegra Health System which is stored by Centegra Health System. Centegra Health System may release the ImPACT test results to my child's/student athlete's primary care physician or other treating medical professional as necessary for treatment following a concussion. **Name of Primary Care Physician/ Pediatrician:** ______________________________ **Phone # of Primary Care Physician/Pediatrician:** ____________________________ **Participant Signature:** ______________________________ **Date:**___________ **Parent Name (please print):**____ **Parent Signature:** ____________________________________**Date:** __________

(The following information to be filled in by Screening Team)

Have you ever concurred a concussion?____
If so, how many and when?____

Screening:		Description:	(✓)	
		Concussion/ Impact		