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

Concussion Registration Form 2016/2017

	Baseline Concussion
Organization	
Legal Name	First: _____ MI: _____ Last:_____
Address	
City/Zip	
Phone	
E-Mail Address of Parent	
Age, Date of Birth, Gender and H/W	Age:_____ Date of Birth:_____ Gender:_____ Height:_____ Weight:_____
	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. **Parent Name (please print):**_____ **Parent Signature:** _____**Date:** _____ **Please circle any of the following that apply:** **ADD/ADHD** **Dyslexia** **Autism** **Have you ever had a concussion?**_____ **If yes, how many and when?**_____

For Admin Use Only:		
Concussion/ Impact		