CENTEGRA HEALTH SYSTEM ◆ Concussion Clinic ◆ **(815) 759-4342**

Concussion Registration Form

	IMPACT Baseline Concussion
Organization/Team	
Patient Name	First: _____ MI: _____ Last:_____
Phone:	
Email Address of Parent:	
	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?**_____

Screening Information:		