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. **Name of Primary Care Physician/ Pediatrician:** _______________________________________ **Phone # of Primary Care Physician/Pediatrician:** _____________________________________ **Participant Signature:** ______________________________________ **Date:**_____________ **Parent Name (please print):**____ **Parent Signature:** ____**Date:** ____________ **Have you ever concurred a concussion?**_______________________________________ **If yes, how many and when?**____

For Admin Use Only:		
Concussion/ Impact		