

Parental Consent for ImPACT Testing

Child's Information

Child's Name

Date of Birth

Home Address

Home phone number

City, State, Zip

Parent/Guardian Name

Phone Number

The above named Parent/Guardian shall authorize consent for ImPACT medical testing through OAA Orthopaedic Specialists, for above named child, which will be completed during my absence. If circumstances permit, I would like to have our doctor consulter in connection with such treatment.

Signatures

Parent/Guardian (circle one)

Date