SAINT PETER'S
SPORTS MEDICINE INSTITUTE
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM

562 Easton Avenue
Somerset, NJ 08873
732.565.5455

PATIENT LABEL

School Communication Agreement

Patient's Name: _____ Patient's DOB: _____

I, _____, give my permission for Dr. Arlene Goodman to contact my son's/daughter's school at any time regarding his/her concussion test results, return to play protocol, and/or school accomodation recommendations. I also allow for communication to occur between the school and Dr. Goodman regarding changes to this plan.

Please provide the name of your child's School Athletic Trainer and School Nurse in order to best facilitate communication.

ATHLETIC TRAINER _____

NURSE _____

SCHOOL _____

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____

Date: _____ Time: _____