The Bow School District is currently implementing a concussion management program and has acquired a software tool called ImPACT (Immediate Post Concussion Assessment and Cognitive Testing). ImPACT is a computerized exam utilized in many sports programs to manage concussions by comparing pre and post injury testing. ImPACT can be used to help diagnose concussions and inform treatment plans for head injuries.

At BMS I will be offering Tuesday morning ImPACT Baseline clinics with preregistration. The times will be 7:45-8:30 before school. There is also a possible option to set up an appointment during study hall. The test takes an average of 35-40 minutes

Student in grades 7 - 12 who play contact sports are strongly encouraged to have had an ImPACT test within 2 years prior to participation in their sport. Any students who wish to have a baseline test, should contact their school nurse to arrange a time during the school year for the test.

PRE-REGISTRATION IS REQUIRED by E-MAIL BMS Nurse, Donna Ireland direland@bownet.org to sign-up. For BHS students e-mail the BHS Nurse, Leslie Bean lbean@bownet.org.

The attached Consent Form and Baseline Worksheet should be completed and turned into the nurse prior to the exam.

ImPACT, a non-invasive test, is set up in "video-game" type format and takes about 45 minutes to complete. It tracks information such as memory, reaction time, speed, and concentration. Bow has contracted with Dr. William Storo, a concussion specialist at the Dartmouth-Hitchcock Clinic, to evaluate the Baseline tests for validity and to advise the district on protocols. The data for the test is housed by ImPACT and can be released to your own health care provider upon request. If a concussion is suspected, the athlete will be required to re-take the test. Both the baseline and post-injury test data will be reviewed by Dr. Storo, and tests will be used to inform treatment plans, return to play and "return to learn" school accommodations.

If you have any further questions regarding this program please feel free to contact me at direland@bownet.org

Donna Ireland, RN
BMS Nurse

Consent Form

For use of the Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT)

I have read the attached information. I understand its contents. I have been given an opportunity to ask questions and all questions have been answered to my satisfaction. I agree to participate in the ImPACT Concussion Management Program.

Printed Name of Student _____

Sports played, if any _____

Signature of Student _____

_____

Date

Signature of Parent/Guardian _____

_____

Date

Baseline Worksheet

I. Demographic and Background Information

School / Organization: _____
Date of Birth: _____ month _____ date _____year

First Name: _____ Last Name: _____

Height: _____ft _____in Weight: _____ Gender: _____ male _____ female

Handedness: _____ right _____ left _____ ambidextrous (both right and left)

Native Country / Region: _____

Native Language: _____

Second Language: _____ (only if fluent in speaking and writing)

Years of education completed excluding kindergarten: _____
(e.g., high school senior is 11 years)

Check any of the following that apply:

_____ Received speech therapy
_____ Attended special education classes
_____ Repeated one or more years of school
_____ Diagnosed attention deficit disorder or hyperactivity
_____ Diagnosed learning disability

While in school, what type of student were / are you?

_____ Below Average _____Average _____Above Average

Current Sport: _____

Current position / event / class: _____

(e.g., quarterback, forward, 1st base, etc.)

Current level of participation: _____(e.g., junior high, high school)

Years of experience at this level: _____ (0 - 4)
(e.g., number of years in high school, high school senior = 3)

Please list your 5 most recent concussions:

_____ month _____ year
_____ month _____ year
_____ month _____ year
_____ month _____ year
_____ month _____ year

Concussion History

_____ Number of times diagnosed with a concussion (excluding current injury)
_____ Total number of concussions
_____ Total number of concussions that resulted in confusion
_____ Total number of concussions that resulted in difficulty with memory for events that occurred immediately after injury
_____ Total number of concussions that resulted in difficulty with memory for events that occurred immediately before injury
_____ Total number a games that were missed as a direct result of all concussions combined

Indicate if you have had any of the following:

_____ yes _____ no Treatment for headaches by physician
_____ yes _____ no Treatment for migraine headaches by physician
_____ yes _____ no Treatment for epilepsy / seizures
_____ yes _____ no Treatment for brain surgery
_____ yes _____ no Treatment for meningitis
_____ yes _____ no Treatment for substance abuse / alcohol abuse
_____ yes _____ no Treatment for psychiatric condition (depression, anxiety)

Have you been diagnosed with any of the following?

_____ yes _____ no ADD/ ADHD
_____ yes _____ no Dyslexia
_____ yes _____ no Autism

Have you participated in any strenuous exercise and/or exertion in the last 3 hrs?

_____ yes _____ no

Date of your last concussion: _____ month_____date_____year

Number of hours slept last night: _____ approximate if uncertain

Please list any PRESCRIPTION medication(s) you are currently taking:

_____

_____

_____

_____

_____