BISHOP MCDEVITT SPORTS MEDICINE

Dear Parent/Guardian,

Bishop McDevitt High School School is currently implementing an innovative program for our student-athletes. This program will assist our team physicians/athletic trainer in evaluating and treating head injuries (e.g., concussion). In order to better manage concussions sustained by our student-athletes, we have acquired a software tool called ImPACT (Immediate Post Concussion Assessment and Cognitive Testing). ImPACT is a computerized exam utilized in many professional, collegiate, and high school sports programs across the country to successfully diagnose and manage concussions. If an athlete is believed to have suffered a head injury during competition, ImPACT is used to help determine the severity of head injury and when the injury has fully healed.

All athletes are required to take the computerized exam before beginning sport practice or competition. This non-invasive test is set up in "video-game" type format and takes about 15-20 minutes to complete. It is simple, and actually many athletes enjoy the challenge of taking the test. Essentially, the ImPACT test is a preseason physical of the brain. It tracks information such as memory, reaction time, speed, and concentration. It, however, is not an IQ test.

If a concussion is suspected, the athlete will be required to re-take the test. Both the preseason and post-injury test data is given to the approved concussion specialist of your choice to help evaluate the injury. (The list of approved concussion specialists is included at the end of this form). The information gathered can also be shared with your family doctor. The test data will enable these health professionals to determine when return-to-play is appropriate and safe for the injured athlete. If an injury of this nature occurs to your child, you will be promptly contacted with all the details.

I wish to stress that the ImPACT testing procedures are non-invasive, and they pose no risks to your student-athlete. We are excited to implement this program given that it provides us the best available information for managing concussions and preventing potential brain damage that can occur with multiple concussions. The Bishop McDevitt High School administration, coaching, and athletic training staffs are striving to keep your child's health and safety at the forefront of the student athletic experience. Please return the attached page with the appropriate signatures. If you have any further questions regarding this program please feel free to contact me at (717).236.7973 ext 2360 or pgraves@bishopmcdevitt.org.

Sincerely,

Paul Graves, LAT, ATC

Bishop McDevitt Approved Concussion Specialist:

Hershey Medical Center Concussion Clinic
(717).531.8752
Penn State Hershey Medical Center
500 University Drive
Hershey, PA 17033
Dr. Bramley
Dr. Onks
Dr. Silvis
Dr. Jacobs

Dr. Pujalte
Arlington Orthopedics
(717).652.9555
805 Sir Thomas Court
Harrisburg, PA 17109

Dr. Michael Cordas
Pinnacle Health
4310 Londonderry Road
Harrisburg, PA 17109

CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for (name of child) _____

(child's date of birth) _____

to have a post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) administered at Bishop McDevitt High School. I understand that my child may need to be tested more than once, depending upon the results of the test, as compared to my child's baseline test, which is on file at McD. I understand there is no charge for the testing.

Bishop McDevitt High School may release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to my child's primary care physician, neurologist, or other treating physician, as indicated below.

I understand that general information about the test data may be provided to my child's guidance counselor and teachers, for the purposes of providing temporary academic modifications, if necessary.

Name of parent or guardian: _____

Signature of parent or guardian: _____

Date: _____

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of doctor: _____

Name of practice or group: _____

Phone number: _____

Student's home address: _____

Parent or guardian phone numbers (please indicate preferred contact number & time if necessary):

_____(H) _____(W)

_____(cell)