OLDHAM COUNTY BOARD OF EDUCATION
ADMINISTRATIVE REGULATION –9060.02-F

CONSENT OF PARENT OR GUARDIAN FOR ImPACT™ TESTING
Of HIGH SCHOOL STUDENT ATHLETES

Relates to: OCBE Administrative Regulation 9060-AR, OCBE Form 9060.01-F

Dear Parent/Guardian,

In order to better manage concussions sustained by our student-athletes, the school district has partnered with Baptist Hospital Northeast, the provider of our athletic training services, to acquire a software tool called ImPACT™ (Immediate Post Concussion Assessment and Cognitive Testing). ImPACT™ is a leader in computerized neurocognitive assessment tools and services, which are becoming more prevalent in recognizing and managing head injuries. (Additional information about ImPACT™ can be found at www.impacttest.com.)

All high school athletes must complete the ImPACT exam prior to athletic participation. This test is set up in a "video-game" style format and takes 30-35 minutes to complete. The ImPACT™ test is a pre-season physical of the brain that tracks information such as memory, reaction time, speed, and concentration, but it is not an IQ test. The ImPACT™ test is non-invasive and poses no risks to your child.

We will be testing all in-coming freshman, sophomores, juniors and seniors, as well as middle school students who are participating at the high school level. Each student athlete will be tested once prior to beginning sports practice or competition and will be tested again if they sustain a head injury. Student athletes sustaining a concussion will continue to be tested using the ImPACT™ test until their post-concussion results are within the normal ranges of their baseline test. There is no charge for this testing.

The protocol for managing these injuries and returning athletes to play is briefly outlined below.

1. **All athletes who sustain head injuries are required to be evaluated and cleared by their primary care physician (PCP)**, prior to being permitted to progress to activity. This includes athletes who were initially referred to the emergency department.
2. **In addition to the physician exam, 2 other criteria must be met prior to clearance for return to play**: (a) the student athlete must be asymptomatic, at rest and with exertion, and (b) the athlete's post-injury neurocognitive testing data must be within normal range of the athlete's baseline ImPACT™ scores.
3. Athletes who have been cleared to return to activity follow a graduated procedure, as recommended by "The Summary and Agreement Statement of the 2nd International Conference on Concussion in Sport, Prague 2004" and the National Athletic Trainers' Association Position Statement on Management of Sport-Related Concussion (2004).

By signing the Parent Consent Form you authorize the Oldham County school district to release medical information and ImPACT™ results to your child's Primary Care Physician. Your child's health and safety are an important part of the student athletic experience and we are pleased to implement this program. If you have any further questions regarding this program please feel free to contact your school Athletic Director or Athletic Trainer.

Sincerely,

Oldham County Schools Athletic Trainers

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Of HIGH SCHOOL STUDENT ATHLETES

STUDENT NAME: _____

STUDENT ADDRESS: _____

STUDENT DATE OF BIRTH: _____

SCHOOL: □ North Oldham HS □ Oldham County HS □ South Oldham HS

□ North Oldham MS □ Oldham County MS □ South Oldham MS □ East Oldham MS

GRADE: □ Freshman □ Sophomore □ Junior □ Senior

□ 8th grade □ 7th grade □ 6th grade

I hereby give permission for my child to complete an ImPACT™ baseline test and post-concussion ImPACT™ tests administered at the high school for which my student is competing as needed. I understand that my child may need to complete the test more than once, depending on the results of the test. I understand there is no charge for the testing.

I further agree that the high school may release the ImPACT™ results and any other information related to his or her head injury to my child's primary care physician, neurologist, or other physician involved with my child's care.

_____ _____

Name of parent or guardian *Date*

_____

Signature of parent or guardian

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

HOME: _____ □ preferred

WORK: _____ □ preferred

CELL: _____ □ preferred

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of Physician: _____

Practice or Group Name: _____

Telephone number: _____