Park Hill School District

Building Successful Futures • Each Student • Every Day

ImPACT™

Consent Form

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

We have read the Parent Information Letter. We understand its contents. We have been given an opportunity to ask questions and all questions have been answered to our satisfaction. We agree to participate in the ImPACT Concussion Management Program.

We have also received and read the MSHSAA materials on Concussion, which includes information on the definition of a concussion, symptoms of a concussion, what to do if you have a concussion, and how to prevent a concussion.

Printed Name of Athlete _____

Sports/Activities _____

_____ _____

Signature of Athlete Date

_____ _____

Signature of Parent Date

Optional – Refusal to Consent to ImPACT baseline testing

I/We understand the Park Hill School District and MSHSAA have identified concussions as a potential long-range health issue for student athletes and activity participants. The primary focus of this program is the safety and protection of our students. I/We wish to ***opt-out*** *my student, _____, from the ImPACT Concussion baseline assessment. Although my student is not participating in the ImPACT baseline assessment, I understand my student will be required to follow the MSHSAA and Park Hill School District concussion return to play guidelines.* **Do NOT sign below if participating.**

_____ _____

Signature of Parent Date

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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)

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I. Demographic and Background Information (cont'd)

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:

_____

_____