

*School Administrative Unit 67
Bow and Dunbarton, New Hampshire School Districts
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Dr. Dean S. T. Cascadden
Superintendent of Schools

Mr. Duane C. Ford
Assistant Superintendent

Ms. Tamara A. MacAllister
Director of Student Services

Dr. Donald R. Gage, II
Director of Curriculum

Dear Parent/Guardian of Bow/Dunbarton Student Athletes,

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.

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.

Bow High School or Bow Memorial School students who participate in the following 2016/2017 Fall Sports- Football, Soccer, Spirit and Field Hockey are being offered ImpACT baseline exams on Tuesday, August 9th and Thursday, August 11th at Bow High School from 8AM to 2PM.

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

The attached Consent Form and Baseline Worksheet should be completed and brought to the nurse at the time of 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.

Students who are unable to attend either the Aug. 9th or 11th test dates, or students involved in other sports who wish to have a baseline test, should contact their school nurse to arrange a time during the school year for the test.

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

Sincerely,

Dean S.T. Cascadden
Superintendent of SAU 67

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 _____

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:
