Sports Medicine & Training Center

RAMS
Ladue Horton Watkins High School

Dear Parents,

Concussions are a common injury that have become more prevalent in the past few years, and are often difficult to diagnose and treat. Through our Medical Provider at Sports Medicine & Training Center, Ladue's student athletes have the opportunity to be tested for concussions using a state of the art computer system known as **ImPACT** (Immediate Post Concussion Assessment & Cognitive Testing). This program assists our team physicians/athletic trainers in evaluating and treating concussions. **ImPACT** is a sophisticated, research-based computer test utilized in many professional collegiate and high school sports programs across the country.

The computerized exam is given to athletes before beginning a sport. This non-invasive test is set up in video game type format and takes about 30 minutes to complete. It is simple, and many athletes actually enjoy the challenge of taking the test. Essentially, the **ImPACT** test is a pre-season physical of the brain. **ImPACT** tracks information such as memory, reaction time, speed, and concentration. It is not to be confused or associated with an IQ test. Because this is an online system, the results will follow the athlete throughout the course of their high school career as well as into college and beyond, making it a very valuable instrument. Many of out student athletes have already begun to use this software and it has proven to be most effective and useful.

When a concussion is suspected, a follow-up test is administered to see if the results have changed. This comparison helps to diagnosis and manage the concussion. Follow-up tests can be administered over days or even weeks so we can continue to track the injury. The information would be collected and analyzed through your chosen physician.

We realize that this program may not be of interest to all athletes, which is why the program is strictly voluntary. The cost is $15 per athlete for the baseline test and usually takes 30 minutes to complete. The testing dates will be August 9th & 10th @ 7:00 p.m. and 7:45 p.m. in the library at the high school. Each student will ***need*** to bring a signed consent form (enclosed) and either a check (written out to SMTC) or cash to their testing session. As an FYI, our high school treated 27 head injuries in 9 different MSHSAA sponsored sports last year. The shortest amount of days the athlete remained out was 7 days, while the longest duration an athlete remained out was 241 days.

If your are interested in **ImPACT** testing, please contact Kelsey Towey, Ladue's Head Athletic Trainer, by email (below) to **reserve a testing spot**. Only 20 students per night are allowed. If both sessions are filled up, we can discuss other options. Testing will start exactly on time so *please* arrive early to your session.

Sincerely,

Nick Gianino, Athletic Director
Ladue Horton Watkins High School
ngianino@ladueschools.net
(314) 983-5406

Kelsey Towey, ATC, LAT
Sports Medicine & Training Center
kelseyt@smtcstl.com
(314) 809-6531

ImPACT Consent Form

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 baseline test administered at Ladue Horton Watkins 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 will be kept on file at Ladue High School.

I understand there is a charge of $15 for the testing. Please make checks payable to SMTC and include with this consent form. Reminder, participants must reserve a space prior to arriving. Contact Kelsey Towey to make a reservation.

Ladue Horton Watkins High School may release the ImPACT 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 Primary Doctor: _____

Name of practice or group:_____

Phone number: _____

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

Home: _____

Work: _____

Cell: _____

Please make checks out to:
SMTC