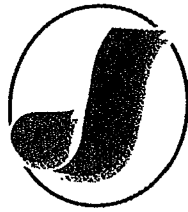


Jones Memorial Hospital
Rehabilitation Department
191 North Main Street
Wellsville, New York 14895
Phone: (585) 596-4011
Fax: (585) 596-4012

February 15, 2013

Dear Parent or Guardian:

The Jones Memorial Hospital Rehabilitation Department is offering a free screening assessment to all students who participate in athletic activities to assist physicians to manage concussions when they occur. This screening assessment is being performed in conjunction with local physicians. It is intended to assist physicians to determine whether and when it is safe for your child to return to athletic activities if your child should sustain a concussion at any school or district-sponsored sports event or related activity. According to the New York State Education Department (NYSED), students who sustain, or are suspected to have sustained, a concussion during athletic activities must be removed **immediately** from such activities. Students may **not** return to athletic activities, until they have been symptom-free for a minimum of 24 hours after the injury. Further, your child must be evaluated by a physician and the physician must provide written approval for your child to return to his/her athletic activities. **The Wellsville Central School district concussion protocol must still be followed.**

The Biodex Balance System™ is used to assess the student's baseline scores before a concussion occurs. The Biodex Concussion Management Program is then used to diagnose and manage concussions should your child be injured. This program uses evidence-based protocols to facilitate decisions by physicians about whether it is medically safe for your child to return to athletic activities. The Biodex Clinical Test for Sensory Integration of Balance (CTSIB) consists of four 20-second trials that assess balance. Your child will stand on a firm surface with his/her eyes opened/eyes closed and then stand on a foam surface with eyes opened/eyes closed. If your child later incurs a suspected concussion, he/she may be referred to the Jones Memorial Hospital Rehabilitation Department. The scores from the screening performed now will be compared to his/her post-injury scores. This comparison provides data which your physician needs to decide whether your child can return to full athletic activity. This testing is not to replace the Wellsville Central School District concussion protocol. It will be used in conjunction with it and the school protocol still MUST be followed.

In order for your son/daughter to be seen by the Jones Memorial Hospital Rehabilitation staff, we must first have your written permission to allow the physical therapist to complete the Clinical Test for Sensory Integration of Balance (CTSIB) by Biodex Balance System™ at Wellsville Central School. Testing will the week of March 18, 2013 and will be completed during physical education classes. Please note that we require the signature of **both** the student **and** the parent/guardian to permit the screening. The name of the specific therapist performing the test will be filled in at the top of the form the day of the test.

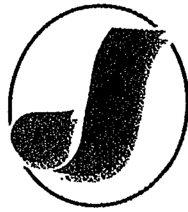
Please return the permission slip to the High School/Middle School Main Office attention: JMH PT/ Christy Hart by March 13, 2013. If you have any questions or concerns, please contact the Jones Memorial Rehabilitation Department at 585-596-4011.

Thank you for your support of this program. We look forward to assisting you with concussion assessment and management to enable your son or daughter to safely return to full athletic activity should a concussion occur.

Sincerely yours,

Christy Hart, PT

Scott Siddall, PT, DPT



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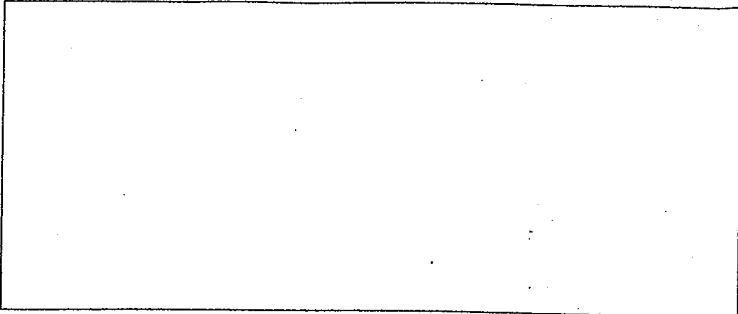
Scott Siddall, PT, DPT

CONSENT FOR SCREENING EXAM FOR CONCUSSION MANAGEMENT

CONSENT



Form #

1. I hereby authorize(Jones Memorial Hospital Physical therapist) ______________________ to perform upon me/the named patient a screening examination for management of concussions. I understand that the purpose of this screening is to establish a baseline score on the Biodex Balance System™. This information will be used for comparison if, at a later time, I/the patient sustain a concussion while participating in sports.

2. I hereby release the screening physical therapist, Jones Memorial Hospital, Jones Memorial Hospital Rehabilitation Department, and all Hospital staff from all liability and responsibility in connection with this screening examination.

3. I understand that my/the patient's test results will be retained by the Jones Memorial Hospital Rehabilitation Department. Should I/the patient sustain a concussion, I am aware that I/the patient will be referred to the Jones Memorial Hospital Rehabilitation Department for further care and treatment. I further understand that I am responsible for all costs associated with such follow up. **I am also aware that performance of this screening examination does not create a provider/patient relationship between the physical therapist who performs it and me/the patient.**

4. The physical therapist has fully explained to me the purpose of the examination and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed examination, including not performing it. The risks of the alternatives have also been explained to me. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

5. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from this examination.

6. I confirm that I have read and fully understand the above information and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above which do not pertain to me.

Patient/Student Signature ▶ ______________________ Print Name: ______________________

Relative/Guardian: ______________________

Relationship to Patient ______________________ Date / Time: ______________________

Witness ▶ ______________________ Date / Time: ______________________

Interpreter (if required) ▶ ______________________ Date / Time: ______________________

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no examination) the proposed examination, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Physical Therapist Signature ▶ ______________________ Date / Time: ______________________

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD