2012 Concussion Management Team Information Survey

School District _____ Date __ - __ - ____

Athletic Director / Dir of PE _____

PH ___ - ___ - ____ C ___ - ___ - ____ Email _____

School Nurse

PH ___ - ___ - ____ C ___ - ___ - ____ Email _____

School Physician

PH ___ - ___ - ____ C ___ - ___ - ____ Email _____

Athletic Trainer

PH ___ - ___ - ____ C ___ - ___ - ____ Email _____

Please list your Concussion Management Team members and indicate the contact person with an *. Please add contact information for any additional members.

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_____

Are you currently using ImPact? Y ___ N ___

If yes, who is coordinating this? _____

Does yours school have a Board approved Concussion Management Policy in place? Y __ N __

Would you like assistance in setting up your team, using Impact, policy implementation, resources or any other phase of concussion management? If yes, how can our Section IX CM Team be of assistance to you? _____

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