Brunswick County Schools
Head Injury Assessment Tool

Student's Legal Name _____ **School:** _____

Grade: _____ **Date of Injury:** _____ **Time:** _____

Description of Injury:
(Include information about where and how the injury occurred, any loss of consciousness and/or memory and for how long, seizures following the injury or previous concussions if any.)

_____

_____

_____

OBSERVED SIGNS	**0 MINUTES**	**15 MINUTES**	**30 MINUTES**	**____ MINUTES Just Prior to Leaving**
Appears dazed or stunned				
Is confused about events				
Repeats questions				
Answers questions slowly				
Cannot recall events prior to the hit, bump or fall				
Cannot recall events after the hit, bump or fall				
Loses consciousness (even briefly)				
DANGER SIGNS				
Convulsions or seizures				
Difficulty recognizing people or places				
Slurred Speech				
Drowsiness or cannot be awakened				
PHYSICAL SYMPTOMS				
Headache or "pressure" in head				
Nausea or Vomiting				
Balance problems or dizziness				
Fatigue or feeling tired				
Blurry or double vision				
Sensitivity to light				
Sensitivity to noise				
Numbness or tingling				
Does not "feel right"				
COGNITIVE SYMPTOMS				
Difficulty thinking clearly				
Difficulty concentrating				
Difficult remembering				
Feeling more slowed down				
Feeling sluggish, hazy, foggy or groggy				
EMOTIONAL SYMPTOMS				
Irritable				
Sad				
More emotional than usual				

RESOLUTION OF INJURY

___ Student returned to class

___ Student sent home

___ Student referred to health care professional for evaluation

PERSONNEL COMPLETING FORM - STAFF/ADMINISTRATOR SIGNATURE: _____