Concussion / Traumatic Brain Injury / Head Injury
Health Assessment Form

Student Name: _____ Grade: ____ Date of Birth: _____
SAC Site: _____ Parent / Guardian: _____
Phone: (H) _____ (W) _____ (C) _____
Physician / Clinic: _____ Phone: _____
Hospital Preference: _____

Type of Injury: _____
Date of Injury: _____ Hospitalized due to injury? ___ no ___ yes, explain:
_____
_____
List type and dates if suffered multiple injuries:
_____
_____
_____
_____
Did your child have restrictions / limitations during recovery? ___ no ___ yes, explain:
_____
_____
_____
_____
Does your child currently have any restrictions / limitations? ___ no ___ yes, explain:
_____
_____
_____
_____
If your child has a head hit while at school age care are there specific signs / symptoms staff need to be aware of? ___ no ___ yes, explain:
_____
_____
_____
Does your child require any medications in relation to a head injury while at school age care? ___ no ___yes, explain: _____
_____
(All medications taken while at school age care require a current medication form signed and dated by a doctor and parents/guardian)
Is there anything the school age care staff should know about your child's concussion/traumatic brain injury/head injury? _____
_____
_____

Parent/Guardian signature: _____ Date: _____

All health form are valid for one calendar year from the date they are signed and dated.

05/07/2018