Incident Form Regarding Injury to the Head

Today's Date: _____
Child's Name: _____ Child's Date of Birth: _____

Describe When and How Injury Occurred: (Include cause and force of the hit to the head, type of surface or object struck, and location of head where the blow occurred).

_____

_____

Signs/Symptoms: Check any changes observed following the blow to the head. Check all that apply:

Vomiting ____
Sick to stomach ____
Decreased strength ____
Decreased coordination or poor balance ____
Decreased sucking/swallowing ____
Decreased ability to lift or hold head ____
Decreased smiling/vocalizing ____
Decreased language/communication ____
Decreased tolerance to light ____
Decreased appetite ____
Frequent rubbing of eyes ____
Decreased ability to focus eyes ____
Extreme irritability/increased crying ____
Unequal pupil size of eyes ____
Swelling of the Soft Spot ____
Sleep changes ____
Appears dazed or confused ____
Acts as if head hurts (headache) ____
Lost consciousness ____

Estimate of duration of any of the above signs/symptoms:

Number of Minutes ____, Hours ____, Days ____, Weeks ____, Longer ____

Children who experience one or more of the signs and symptoms (listed above) following a blow to the head should be referred to a health care professional for further evaluation.

Person Completing the Form:
_____

Were parents notified? Yes ____ No____ If yes, how? _____

_____

_____

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