Traumatic Brain/Head Injury (TBI) Signs and Symptoms
INCIDENT REPORT FORM for Children Ages 0-4

Educator Resource 5

Instructions: When a child is brought to the office with a brain/head injury use the checklist below to determine which symptoms are immediately observed/seen. Monitor for all symptoms again in 15 minutes then at 30 minutes. Should one or more of these symptoms be observed/seen in the child refer to a health care professional immediately that is experienced in concussion evaluation and guidance for treatment. **If child is in your care beyond 30 minutes, document symptoms up to the exact time (minutes and/or hour) prior to the child leaving.

Symptoms to Observe	Arrival-onset of symptoms	15 minutes	30 minutes	Minutes – prior to leaving
Loss of consciousness				
Acts as if head hurts (headache)				
Appears dazed or confused				
Vomiting				
Sick to stomach				
Unequal pupil size of eyes				
Swelling of the Soft Spot				
Sleep changes				
Extreme irritability/increased crying				
Decreased ability to focus eyes				
Frequent rubbing of eyes				
Decreased strength				
Decreased tolerance to light				
Decreased coordination or poor balance				
Decreased sucking/swallowing				
Decreased ability to lift or hold head				
Decreased smiling/vocalizing				
Decreased language/communication				
Decreased appetite				
Seizures				
Memory Loss				

Name of child _____Age _____

Date/Time of Brain/Head Injury _____ Where/How it occurred (be sure to state what caused hit/blow to head and force of injury) _____

_____Description of Injury (include any previous concussions if known) _____

Signature/Date/Time of Observer (at release): _____

Name of parent notified _____ **Name copy given to**_____

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