INJURY/INCIDENT REPORT

❑ **Check if head injury (SEE BACK OF FORM)** **TEACHER/AIDE COMPLETE**

PARENTS, if the above box is checked, please refer to the HEAD INJURY CHECKLIST and use this check list to observe your child. Please seek medical attention if you observe any of these items.

Date of Accident or Injury:______________________________________Time:_______________

Name of Injured:____Grade:_______________

Location of Accident/Injury:____

Description of Accident/Injury (teacher/aide describe fully): Did teacher/aide witness? Students witness?

____

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PARENTS: Use the checklist on reverse side to help assess whether or not to follow up with your child's doctor. If your child had a head injury, we will not permit your child to participate in physical activities for 24 hours after the incident unless directed by you or your child's doctor.

❑ My child may resume activities upon return to school.

❑ My child will be seeing a doctor. Do not allow my child to participate in any physical activities until cleared.

Action taken by office staff: (if head injury, no PE, recess or other physical activity for 24 hours)

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How and when were parents notified by office?

____

Specific instructions from parents: (either from phone call or added by parent)

____

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301 N. Madison Avenue, Grove City, PA 16127 * telephone: 724-458-5253 * fax: 724-458-5259
E-mail: office@GroveCityChristianAcademy.com * website: www.GroveCityChristianAcademy.com

HEAD INJURY CHECKLIST

(Check any that apply)

Observations	**Office Visit**		
Eye/light test	❑	pupils dilated? Y/N _____	unequal pupils? Y/N ______
Word test	❑		

	Office Visit	**Teacher Observation**	**Parent Observation**
Thinking/Remembering:		(Check any that apply)	
Difficulty thinking clearly	❑	❑	❑
Feeling slowed down	❑	❑	❑
Difficulty concentrating	❑	❑	❑
Difficulty remembering new info	❑	❑	❑
Physical:			
Headache	❑	❑	❑
Fuzzy or blurred vision	❑	❑	❑
Nausea or vomiting (early on)	❑	❑	❑
Dizziness	❑	❑	❑
Sensitivity to noise or light	❑	❑	❑
Balance problems	❑	❑	❑
Feeling tired, having no energy	❑	❑	❑
Emotional/Mood:			
Irritability	❑	❑	❑
Sadness	❑	❑	❑
More emotional	❑	❑	❑
Nervousness or anxiety	❑	❑	❑

Notes:

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Staff Signature:____Date:______________

Parent Signature:____Date:______________

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