NEWPORT NEWS TRAUMATIC BRAIN INJURY SCREENING FORM

Student's Name:
Date of Birth:
Student's Grade:
Today's Date:

Student's ID:
Student' School:
Student's Teacher:

Your Name:
Relationship to Student:

Has your child ever been in a car accident, suffered a blow to his/her head, had a bad fall, and/or lost consciousness?

Yes _____ (Describe)
No _____

Describe: (include when, where, how, medical interventions or diagnoses, possible changes in behavior)