Forest Lake Area Schools
Health Services - Nursing

Concussion/Traumatic Brain Injury (TBI) Questionnaire

School Year: _____

Student Name: _____ Birthdate: _____

School Attending: _____ Grade: _____

Parent/Legal Guardian:_____ Relationship to Student: _____

Home Phone: _____ Work: _____ Cell: _____

Parent/Legal Guardian:_____ Relationship to Student: _____

Home Phone: _____ Work: _____ Cell: _____

Primary Physician: _____ Clinic: _____ Phone: _____

Neurologist: _____ Clinic: _____ Phone: _____

1. Has your child ever been diagnosed with a concussion or Traumatic Brain Injury? ☐ Yes ☐ No
   If YES, which one? _____
2. What was the date of your child's head injury(s)? _____
3. Was there loss of consciousness? ☐ Yes ☐ No
4. What caused the head injury? _____
   _____
5. Has your child been hospitalized or needed an ambulance due to a head injury? ☐ Yes ☐ No
   if YES, please explain: _____
6. What were your child's initial symptoms?_____
   _____
7. Is your child still experiencing symptoms from the head injury? ☐ Yes ☐ No
   If YES, please describe: _____
8. Is your child still receiving care from a health care professional for the injury? ☐ Yes ☐ No
   If YES, please explain: _____
9. Does your child need any accommodations while at school due to the injury? ☐ Yes ☐ No
   If YES, please provide the health office with the accommodations from the healthcare professional.
10. How many concussions has your child sustained? _____

Complete Back Side

11. Is there anything else you would like the school to know about your child's health/allergies? _____

_____

_____

Parent/Legal Guardian Signature: _____ Date: _____

Please note:

- If your child has a history of a concussion and/or TBI, we request that you make accommodations with the health office regarding your child's accommodations & signed authorizations/forms