



Please return survey
to your school nurse

COLUMBUS CITY SCHOOLS BRAIN INJURY SURVEY

On the Health Services Parent Questionnaire, you indicated that your child may have had an injury to their brain. In order to collect additional information regarding this possible injury we would like you to complete this brief Brain Injury Survey. In Ohio, a child may qualify for special education services under the category of *traumatic brain injury* if the child has injury to the brain caused by an external physical force (such as a blow to the head or injury from a car accident) or by other medical conditions (such as stroke, brain tumors, lack of oxygen or injuries from medical or surgical treatments).

Name _____
School _____

Grade _____
Age _____

1. Did the child ever hit his/her head, or get hit in the head? Y___ N___
 If yes, did he/she experience any problems such as:

Headaches	Y___ N___	Depression	Y___ N___
Irritability	Y___ N___	Increased Fatigue	Y___ N___
Dizziness	Y___ N___	Poor Judgment	Y___ N___
Anxiety	Y___ N___		
Difficulty concentrating or problems with attention			Y___ N___
Difficulty with long-term or short-term memory			Y___ N___
Difficulty reading, writing or calculating			Y___ N___
Difficulty with preschool or schoolwork			Y___ N___
Poor problem solving			Y___ N___
Changes in relationships with family and friends			Y___ N___

2. Did the child ever lose consciousness or had a concussion? Y___ N___
 For what reason? _____

3. Has the child ever been seen by a doctor in the *emergency room* or been hospitalized? Y___ N___

For what reason? (i.e.: encephalitis, meningitis...) _____

4. Has the child ever had any surgery to the head or brain? Y___ N___
Explain: _____

5. Has the child ever had a stroke? Y___ N___

6. Has the child ever had a seizure? Y___ N___

7. Has the child ever experienced vision or hearing problems? Y___ N___

8. Has the child ever been diagnosed with a brain tumor? Y___ N___

9. Does the child have a diagnosis of head injury? Y___ N___
If yes, what is the nature of the injury? _____

If yes, at what age did the injury occur? _____

10. Please provide additional information regarding possible head injury.

Survey completed by: _____ Date _____
Relationship to child _____

**For more information on Traumatic Brain Injury or how to get special education services contact:
Columbus City School's Department of Psychological Services at 365-5220**

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