

# Brain Injury Screening Form

Maine Pilot Sites 2025

\* Indicates required question

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1. Email \*

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2. Please enter your school's passcode. \*

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3. Student ID Number \*

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4. In your child's life, have they ever been **HIT** in their head, been **HIT** on their head, or have any scars on their head as a result of an injury? For example, a fall, car/ATV/snowmobile crash, a fight, sports, or being hit to the head or face? \*

*Mark only one oval.*

Yes

No

5. In your child's life, have they ever been knocked out or been dazed or confused after a **HIT** to their head? \*

*Mark only one oval.*

Yes

No

6. Has your child ever been **VERY** sick or badly hurt? For example, a brain tumor, stroke, seizures, or near drowning, car crash, bike wreck, a big fall, stopped breathing for a while, or poisoning? \*

*Mark only one oval.*

Yes

No

If the caregiver answered "yes" to ANY of the above questions, continue to next section.

If the caregiver answered "no" to ALL of the above questions, skip the following section and submit the form.

7. How old was your child when they hit their head and/or were very sick or badly hurt? (If multiple instances, document all instances)

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8. Did your child receive medical care when they hit their head and/or were very sick or badly hurt? (If multiple instances, document all instances)

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9. After your child hit their head and/or was very sick or badly hurt, did they have problems that they didn't have before? For example, headaches, trouble sleeping, feeling sick, extra emotional, etc?

*Mark only one oval.*

Yes

No

Symptoms and Resources

10. Does your child have any of the following problems since they hit their head and/or were very sick or badly hurt?

*Check all that apply.*

- headache
- nausea
- vomiting
- stomach-aches
- balance problems
- dizziness
- visual problems
- fatigue
- sensitivity to noise
- feeling slowed down
- difficulty concentrating
- difficulty remembering
- irritability
- sadness
- more emotional
- temper tantrums, defiance
- more easily tearful/crying
- nervousness
- decreased engagement (refusing to play, decreased initiation, quieter)
- increased dependence (clinginess, whining)
- drowsiness
- sleeping less than usual
- sleeping more than usual
- trouble falling asleep
- changes in appetite
- disrupted sleep (nightmares, night terrors)
- bladder incontinence

This child has screened positive for a likely history of brain injury. While not a medical diagnosis, this child and family might benefit from supports, services, or resources.

Insert resources

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