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**Head Injury Assessment Form**

**Senior school, Junior school and Early Years Foundation Stage**

**To be completed by School Nurse or First Aider attending the incident**

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| --- | --- | --- |
| Name of Injured Person |  | |
| Date & time of injury |  | |
| Description of incident  (What, where, how, witnesses, equipment) |  | |
| Injury and findings |  | |
| CONSCIOUS LEVEL  (Please circle one) | **Alert** – eyes open  **Verbal** – eyes open to verbal stimuli  **Pain** – eyes open to painful stimuli  **Unresponsive** – eyes remain closed to all stimuli | |
| **Observations**  Please record if the person has any of these symptoms. | Nausea?  Headache?  Blurred vision? |  |
| If the injury is serious then please check eye-pupil dilation. School Nurse or staff trained to do this | Are the pupils equal and  reacting to light? |  |
| Name of School Nurse or First aider assessor |  | |

This form should be completed to aid assessment and returned to the nurses.

A Sphera report should be completed if indicated

Nurse mobile: 07889 724351