

**CARROLL COUNTY PUBIC SCHOOLS
REPORT OF SUSPECTED NEUROLOGICAL INCIDENT**

School: _____ Date: _____ Time of Incident: _____

Name: _____ Grade/Teacher: _____

Place of Incident: _____ Affected Area: _____

Time	Initial Assessment:	15 Minutes:	30 Minutes:	45 Minutes:	60 Minutes:
Pain Scale 1 – 10 Vital Signs	Pain ____ Temp ____ BP ____ P ____ R ____	Pain ____ Temp ____ BP ____ P ____ R ____	Pain ____ Temp ____ BP ____ P ____ R ____	Pain ____ Temp ____ BP ____ P ____ R ____	Pain ____ Temp ____ BP ____ P ____ R ____
LOC	<input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Unresponsive <input type="checkbox"/> Sedate <input type="checkbox"/> Combative	<input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Unresponsive <input type="checkbox"/> Sedate <input type="checkbox"/> Combative	<input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Unresponsive <input type="checkbox"/> Sedate <input type="checkbox"/> Combative	<input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Unresponsive <input type="checkbox"/> Sedate <input type="checkbox"/> Combative	<input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Unresponsive <input type="checkbox"/> Sedate <input type="checkbox"/> Combative
Eye Movement	<input type="checkbox"/> Normal <input type="checkbox"/> Spontaneous <input type="checkbox"/> Slow <input type="checkbox"/> Nystagmus	<input type="checkbox"/> Normal <input type="checkbox"/> Spontaneous <input type="checkbox"/> Slow <input type="checkbox"/> Nystagmus	<input type="checkbox"/> Normal <input type="checkbox"/> Spontaneous <input type="checkbox"/> Slow <input type="checkbox"/> Nystagmus	<input type="checkbox"/> Normal <input type="checkbox"/> Spontaneous <input type="checkbox"/> Slow <input type="checkbox"/> Nystagmus	<input type="checkbox"/> Normal <input type="checkbox"/> Spontaneous <input type="checkbox"/> Slow <input type="checkbox"/> Nystagmus
Orientation	<input type="checkbox"/> Oriented x's 3 <input type="checkbox"/> Disoriented to Person <input type="checkbox"/> Disoriented to Place <input type="checkbox"/> Disoriented to Thing	<input type="checkbox"/> Oriented x's 3 <input type="checkbox"/> Disoriented to Person <input type="checkbox"/> Disoriented to Place <input type="checkbox"/> Disoriented to Thing	<input type="checkbox"/> Oriented x's 3 <input type="checkbox"/> Disoriented to Person <input type="checkbox"/> Disoriented to Place <input type="checkbox"/> Disoriented to Thing	<input type="checkbox"/> Oriented x's 3 <input type="checkbox"/> Disoriented to Person <input type="checkbox"/> Disoriented to Place <input type="checkbox"/> Disoriented to Thing	<input type="checkbox"/> Oriented x's 3 <input type="checkbox"/> Disoriented to Person <input type="checkbox"/> Disoriented to Place <input type="checkbox"/> Disoriented to Thing
Speech	<input type="checkbox"/> Clear & Understandable <input type="checkbox"/> Slurred <input type="checkbox"/> Difficult to Comprehend <input type="checkbox"/> Non-Sensible	<input type="checkbox"/> Clear & Understandable <input type="checkbox"/> Slurred <input type="checkbox"/> Difficult to Comprehend <input type="checkbox"/> Non-Sensible	<input type="checkbox"/> Clear & Understandable <input type="checkbox"/> Slurred <input type="checkbox"/> Difficult to Comprehend <input type="checkbox"/> Non-Sensible	<input type="checkbox"/> Clear & Understandable <input type="checkbox"/> Slurred <input type="checkbox"/> Difficult to Comprehend <input type="checkbox"/> Non-Sensible	<input type="checkbox"/> Clear & Understandable <input type="checkbox"/> Slurred <input type="checkbox"/> Difficult to Comprehend <input type="checkbox"/> Non-Sensible
Responds To:	<input type="checkbox"/> Verbal Stimulus <input type="checkbox"/> Painful Stimulus <input type="checkbox"/> Touch	<input type="checkbox"/> Verbal Stimulus <input type="checkbox"/> Painful Stimulus <input type="checkbox"/> Touch	<input type="checkbox"/> Verbal Stimulus <input type="checkbox"/> Painful Stimulus <input type="checkbox"/> Touch	<input type="checkbox"/> Verbal Stimulus <input type="checkbox"/> Painful Stimulus <input type="checkbox"/> Touch	<input type="checkbox"/> Verbal Stimulus <input type="checkbox"/> Painful Stimulus <input type="checkbox"/> Touch
Pupils	<input type="checkbox"/> PERL <input type="checkbox"/> Unequal <input type="checkbox"/> Un-reactive to Light <input type="checkbox"/> Sluggish <input type="checkbox"/> Dilated	<input type="checkbox"/> PERL <input type="checkbox"/> Unequal <input type="checkbox"/> Un-reactive to Light <input type="checkbox"/> Sluggish <input type="checkbox"/> Dilated	<input type="checkbox"/> PERL <input type="checkbox"/> Unequal <input type="checkbox"/> Un-reactive to Light <input type="checkbox"/> Sluggish <input type="checkbox"/> Dilated	<input type="checkbox"/> PERL <input type="checkbox"/> Unequal <input type="checkbox"/> Un-reactive to Light <input type="checkbox"/> Sluggish <input type="checkbox"/> Dilated	<input type="checkbox"/> PERL <input type="checkbox"/> Unequal <input type="checkbox"/> Un-reactive to Light <input type="checkbox"/> Sluggish <input type="checkbox"/> Dilated
Extremities	<input type="checkbox"/> Active ROM all Extremities <input type="checkbox"/> Flaccid R__ L__ <input type="checkbox"/> Weak R__ L__ <input type="checkbox"/> Posturing	<input type="checkbox"/> Active ROM all Extremities <input type="checkbox"/> Flaccid R__ L__ <input type="checkbox"/> Weak R__ L__ <input type="checkbox"/> Posturing	<input type="checkbox"/> Active ROM all Extremities <input type="checkbox"/> Flaccid R__ L__ <input type="checkbox"/> Weak R__ L__ <input type="checkbox"/> Posturing	<input type="checkbox"/> Active ROM all Extremities <input type="checkbox"/> Flaccid R__ L__ <input type="checkbox"/> Weak R__ L__ <input type="checkbox"/> Posturing	<input type="checkbox"/> Active ROM all Extremities <input type="checkbox"/> Flaccid R__ L__ <input type="checkbox"/> Weak R__ L__ <input type="checkbox"/> Posturing
Other	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness

Treatment/Comments: _____

Child's condition before leaving Health Room: _____

Parent/Guardian Contact: Yes ___ No _____ Time: _____

***HEAD INJURY INFORMATION FORM GIVEN TO PARENT/GUARDIAN Yes No**

****ATTACH TO ACCIDENT REPORT/SERIOUS ILLNESS REPORT**

Signature of School Nurse