

Date: _____

**INDIVIDUAL HEALTH SUMMARY
FOR STUDENT WITH TRAUMATIC BRAIN INJURY**

Student Information

Name: _____ Date of Birth: _____ Age: _____
Parent/Guardian: _____ Address: _____
Home Phone: _____ Work Phone: _____
Emergency Contact: _____ Phone: _____
School: _____ Grade: _____

Emergency Health Care Providers

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

Does this student require an emergency crisis response plan? Yes ___ No ___
(If yes, attach a copy to this summary.)

Does this student have a current health care plan on file? Yes ___ No ___ Location: _____

Medical History: (description of injury, including area(s) affected, length of loss of consciousness and post-traumatic amnesia, and other relevant health information; DO NOT include diagnoses, judgements and opinions made by a health care provider.)

Current Functioning:

Physical Status: _____

Psychological/Behavioral Information: _____

Academic Functioning: _____

Student Name: _____

Does the student require special health care procedures? Yes___ (if yes, complete the following)
No___

<u>Procedures</u>	<u>Person Responsible</u>	<u>Frequency and Location</u>

Are there current medications administered at school? Yes___ (if yes, list below) No___

<u>Purpose of medication</u>	<u>Person responsible</u>	<u>Frequency</u>

Does the student have special dietary needs? Yes___ (if yes, describe below) No___

Does the student have activity restrictions? Yes___ (if yes, describe below) No___

Does the student have adaptive equipment needs? Yes___ (if yes, describe below) No___

Does the student have special transportation needs? Yes___ (if yes, describe below) No___

This summary prepared by: [Name(s) & Title(s)] _____

Date: _____