Traumatic Brain Injury (TBI) Pre- and Post-Injury Checklist

Parent Form

Student Name:		Student ID:	
School Name:		District:	
Date of Birth:		Date of Injury:	
Today's Date:		Observation Settings:	Home / School / Hospital Other:
Individual Completing Form:		Relationship to Student:	

This checklist may be used as a method of documenting evidence of a marked contrast of pre- and post-injury capabilities when determining eligibility as required by Rule 6A-6.030153, Florida Administrative Code, *Exceptional Student Education Eligibility for Students with Traumatic Brain Injury*. **Both the *Parent* and *School* Forms are to be completed for the student.**

***Parent Form* Directions:** At least one *Parent Form* must be completed by the child's parent, guardian, or primary caregiver. An additional *Parent Form* may be completed by the student. Using the following scale, circle the numbers that best describe the child for **Pre-injury** and **Post-injury**:

1 = Never/Almost Never 2= Occasionally 3= Usually 4= Always/Almost Always

		Pre-injury					Post-injury			
1)	Recognizes and respects adult authority	1	2	3	4		1	2	3	4
2)	Asks questions to obtain necessary information	1	2	3	4		1	2	3	4
3)	Responds appropriately in small or large group settings (Consider group size, noise level, amount of people)	1	2	3	4		1	2	3	4
4)	Motivated to learn or show interest in new learning	1	2	3	4		1	2	3	4
5)	Answers correctly when asked questions	1	2	3	4		1	2	3	4
6)	Recalls and follows written instructions	1	2	3	4		1	2	3	4
7)	Recalls and follows spoken instructions	1	2	3	4		1	2	3	4
8)	Responds to questions within a given or appropriate amount of time	1	2	3	4		1	2	3	4
9)	Comprehends and follow multi-step instructions	1	2	3	4		1	2	3	4
10)	Is able to express needs, ideas, and comments clearly and without frustration	1	2	3	4		1	2	3	4

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		Pre-injury					Post-injury			
11)	Accomplishes or finishes tasks within a given or appropriate amount of time	1	2	3	4		1	2	3	4
12)	Uses appropriate nonverbal skills (e.g.; gestures, pointing, eye wink) when speaking?	1	2	3	4		1	2	3	4
13)	Makes appropriate choices to solve a problem	1	2	3	4		1	2	3	4
14)	Starts and completes assigned tasks independently (e.g., homework, chores)?	1	2	3	4		1	2	3	4
15)	Identifies what category or group something belongs to by placing items in their proper group and/or category	1	2	3	4		1	2	3	4
16)	Shows anger, frustration, and/or aggressive behavior toward others or toward self	1	2	3	4		1	2	3	4
17)	Displays sociable rather than withdrawn behavior	1	2	3	4		1	2	3	4
18)	Is able to complete activities before becoming fatigued (getting tired)	1	2	3	4		1	2	3	4
19)	Is able to recall events from day to day	1	2	3	4		1	2	3	4
20)	Is able to remember locations around the school or home	1	2	3	4		1	2	3	4
21)	Has the ability to remember daily chores, routine school assignments, or verbal information from day to day	1	2	3	4		1	2	3	4
22)	Is able to learn and remember new information	1	2	3	4		1	2	3	4
23)	Is easily distracted	1	2	3	4		1	2	3	4
24)	Is aware of those things that he/she cannot do or things that are difficult for him/her to do (i.e., aware of self and limitations)	1	2	3	4		1	2	3	4

Additional Observations & Comments:

Please circle "Yes" or "No" to answer each question. If you answered "Yes" to any question, then write a brief explanation in the space provided below the question.

Question		
1. Has your child had any changes in or difficulties with balance?	Yes	No
2. Does your child have sensory difficulties (i.e., avoids sensory input) or need more sensory feedback (e.g., repeatedly hits objects, rocks back and forth)? If yes, please answer the bulleted items below for clarification.	Yes	No
• Change of vision (e.g., loss of vision, visual neglect, double vision, blurry vision)?	Yes	No
• Change of hearing (e.g., loss of hearing, oversensitivity to noise, ringing in ears)?	Yes	No
• Change in taste or smell?	Yes	No
• Change in touch (e.g., oversensitivity to touch; inability to feel pain, touch, hot, cold)?	Yes	No
3. Does your child have a physical disability or physically limiting condition (e.g., paralysis or weakness in one or both sides of the body, incontinence, difficulty swallowing, seizure disorder, speech impairment)?	Yes	No
4. Does your child have difficulty tolerating movement experiences (e.g., riding in a car or elevator, playing on playground equipment, uncoordinated movements)?	Yes	No

Please write additional comments below:

Signature: ______________________________ Date: ______________