# Summerville Union High School District
## Health Services
### BUMPS OR BLOWS TO THE HEAD

Date_____ School_____ Teacher_____

Dear Parent/Guardian of : _____ received a bump, or blow, on his/her head on the
(Student Name)

_____ by _____
(Exact Area) (Describe accident, distance of fall, etc.)

at_____ AM/PM today.

Since the effects of head injuries are sometimes delayed, continue to observe your child for the next 24 hours.

*IF ANY OF THE FOLLOWING OCCUR, CALL YOUR FAMILY PHYSICIAN AT ONCE:*

1. Headache
2. Persistent vomiting
3. Dizziness
4. Weakness/paralysis of face/limbs
5. Unconsciousness
6. Convulsions
7. Fever over 100 degrees
8. Unusual/increasing drowsiness
9. Blurred vision
10. Bleeding/fluid drainage from ears/nose
11. Change in behavior/personality

☐ Parent notified Time _____

REMARKS (including treatment):

_____

_____
(Person Providing Care)

1 copy to parent (provided by originating staff member)
Original to the Executive Secretary in District Office

_____
(Parent/Guardian acknowledges receipt)