_____ 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)

Parent - White Copy
School Nurse - Yellow Copy

_____
(Parent/Guardian acknowledges receipt)