Head Bump/Injury Sheet

Dear Parent/Teacher, Date _____ Time_____

Today, _____ received a bump to the head.
student's name

____Your student was not symptomatic at that time, but you should watch for any of the following symptoms:

____Your student had the below circled symptoms and an accident report was filed along with a phone call or attempted phone call to you.

- Excessive drowsiness (awake the child at least twice during the night).
- Nausea and/or vomiting.
- Severe, persistent headache
- Double vision, blurred vision, or pupils of different sizes.
- Loss of muscle coordination such as falling down, walking strangely, or staggering.
- Any unusual behavior such as being confused, breathing irregularly, or being dizzy.
- Convulsion.
- Bleeding or discharge from an ear.
- Weakness of either arm or leg
- Hyperactivity
- Severe stiffness of neck
- A change of temperature
- Difficulty with speech
- Loss of consciousness
- Seizures

CONTACT YOUR LOCAL DOCTOR OR EMERGENCY ROOM IF YOU NOTICE ANY OF THE ABOVE SYMPTOMS OVER THE NEXT 24 HOURS.

____ No symptoms noted, no need to notify unless one symptom was noted during the same day as the incident.

____ Circled symptoms noted and time noted beside them

____ As discussed by telephone

____ Unable to contact by telephone

_____
Teacher/ Admin/ Aide/ Nurse

_____
Contact phone number

Copies to:___ Home
___ teacher
___ Health folder

Revised 11/14/11