HEAD INJURY LETTER

Student's Name: _____

School: _____ Date: _____

Dear parent/guardian:

Your child received a bump or blow to his/her head on the *(describe area of head)* _____
by *(describe the cause or force of the hit to head)* _____
today at _____ am/pm. **If your child experienced *one or more* of the Signs & Symptoms below, s/he should see a health care provider.**

Signs and Symptoms of head injury can show up right after an injury or may not appear until hours or days after an injury. It is important to watch for changes in how your child is acting or feeling and if signs and symptoms are getting worse. If your child reports one or more of the symptoms listed below, or if you notice the symptoms yourself, seek immediate medical attention for your child.

HEAD INJURY SIGNS & SYMPTOMS OBSERVATION CHECKLIST	**Staff Observation**	
Call 9-1-1 immediately for the following:	YES	NO
Loss of consciousness – even briefly		
Not opening eyes, slow to respond, confused, repetitive questioning		
Weakness, paralysis, or numbness		
Seizures or convulsions		
Worsening of any other symptoms (below) during observation		
Significant bleeding from the scalp		
Neck pain		
Refer to health care provider for o*ne or more* of the following:		
Can't recall events *prior* to the hit, bump, or fall		
Can't recall events *after* the hit, bump, or fall		
Headache		
Vomiting more than once		
Balance problems or dizziness		
Blurry or double vision		
Sensitivity to light or noise		
Difficulty thinking clearly and/or shows confusion/dazed		
Change in behavior (irritable, emotional, etc.)		
May need stitches		

Resolution:

No Signs & Symptoms

___No symptoms observed
___Student returned to class
___Copy of letter sent to Parent/Guardian/Teacher(s)

Yes, Signs & Symptoms Present

___Parent/Guardian notified (time/whom)_____/_____
___Emergency services activated (**9-1-1**)
___Student sent home/referred to health care provider
___Teacher(s) and Nurse notified

Signature & Title of person completing this form: _____

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