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		
Slow to respond, confused, slurred speech		
One pupil larger than the other		
Weakness, tingling, numbness, decreased coordination		
Seizures or convulsions		
Blood, clear fluid coming from nose, ears		
Neck pain		
Severe headache		
Worsening of any other symptoms		
Refer to health care provider for o*ne or more* of the following:		
Can't recall events *prior* to or *after* the hit, bump, or fall		
Headache		
Recurring vomiting		
Dizziness		
Blurry or double vision		
Sensitivity to light or noise		
Difficulty thinking clearly		
Change in behavior (irritable, emotional, etc.)		
Increased swelling at site of injury		
Ringing in the ears		
Loss of smell or taste		
Continued sleepiness		
May need stitches		

RESOLUTION OF INJURY

Disposition:	☐ No signs or symptoms observed-returned to class ☐ Symptoms observed-sent home ☐ No signs or symptoms observed-sent home Contacted: ☐ Parent ☐ Authorized Adult ☐ Emergency Services (9-1-1)	
Parent Communication:	Parent (name): _____	☐ Phone call ☐ Voicemail Message #_____
		☐ Email ☐ Unable to reach parent by phone or email
	Parent informed that medical care is advised ☐ Yes ☐ No	
Head Injury Letter:	Copy of letter sent to: ☐ Parent/Guardian ☐ Teacher ☐ Student's Health File	
Comments:		

Signature & Title of person completing this form: _____

CONFIDENTIAL RECORD RETAIN FOR 8 YEARS Revised 10/5/2022