

( ) School District

BUMPS OR BLOWS TO THE HEAD

Date \_\_\_\_\_ School \_\_\_\_\_ Teacher \_\_\_\_\_

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

Parent notified Time \_\_\_\_\_

REMARKS (including treatment):

\_\_\_\_\_

Parent - White Copy  
School - Yellow Copy

\_\_\_\_\_  
(Person Providing Care)