



**HEAD INJURY REPORT**

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

**Dear Parent / Guardian,**

Today, (Student Name) \_\_\_\_\_ received and injury to the head.

Time Occurred: \_\_\_\_\_

Description of incident \_\_\_\_\_

Your child was seen in the office/health room and had the following complaints: \_\_\_\_\_

Treatment provided: \_\_\_\_\_

**Contact your doctor or the emergency room if you observe any of the following symptoms:**

- Confusion or drowsiness
- Nausea and/or vomiting
- Severe headache or worsening headache
- Pupils of different sizes, double vision, blurred vision, or loss of vision
- Irritability, personality changes, or unusual behavior
- Weakness or inability to walk
- Seizures
- Bleeding or discharge from ears, nose, or mouth
- Slurred speech or loss of speech

School Nurse Notified: Yes \_\_\_ No \_\_\_ \_\_\_\_\_, RN Date \_\_\_\_\_ Time \_\_\_\_\_

Building Principal Notified: Yes \_\_\_ No \_\_\_ \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Parent Notified: Yes \_\_\_ No \_\_\_ By: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Signature of Person Completing Report: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Copy to Students Parent/Guardian  
Copies to Building Principal and Nurse

