_____ SCHOOL DISTRICT

BUMPS OR BLOWS TO THE HEAD

You are receiving this notification because your student sustained a head bump or blow and will need to be monitored for the next **24 hours.**

Student's Name: _____ **Date/Time of Incident:** _____

Description of Incident: _____

_____

_____

Treatment Provided:_____

_____

_____

Treatment Provided by: _____

Parent/Guardian Notified:_____ **Time of Notification:**_____

IF ANY OF THE FOLLOWING OCCUR, SEEK EMERGENCY TREATMENT IMMEDIATELY (Call 911 or go to the nearest emergency room):

1. Unconsciousness (unable to wake up) or fainting
2. Convulsions/Seizure
3. Bleeding from ears
4. Paralysis of face/limbs (unable to move)
5. Change in behavior/personality

IF ANY OF THE FOLLOWING OCCUR, CALL YOUR FAMILY PHYSICIAN FOR CARE INSTRUCTIONS:

1. Headache
2. Persistent vomiting
3. Dizziness
4. Weakness/paralysis of face/limbs
5. Fever over 100 degrees
6. Unusual/increasing drowsiness
7. Blurred vision
8. Bleeding/fluid drainage from nose