

NOTIFICATION OF A HEAD INJURY

To the Parents/Guardian of: _____

Date _____

Your child sustained a head injury at school today. A brief description of how the injury occurred is:

At present, he/she exhibiting these signs and/or symptoms:

- | | |
|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Headache or "pressure" in head | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of memory |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Loss of consciousness or responsiveness |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Sleepiness/Drowsy |
| <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Numbness or tingling |
| <input type="checkbox"/> Noise sensitivity | <input type="checkbox"/> Emotional |
| <input type="checkbox"/> Bump or Swelling | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cut | <input type="checkbox"/> None |
| <input type="checkbox"/> Bleeding/drainage from ears and/or nose | |
| <input type="checkbox"/> Slurred speech | |
| <input type="checkbox"/> Slow to answer questions | |
| <input type="checkbox"/> Difficulty with coordination or balance | |
| <input type="checkbox"/> Abnormal behavior; nervousness, anxiety, or perseveration. | |
| <input type="checkbox"/> Unequal pupil size or reaction to light | |
| <input type="checkbox"/> Blurred vision, seeing stars, double vision, and/or sensitivity to light | |

Head injuries can occasionally cause trouble many hours or days later. The symptoms may last only a few minutes or for several months. If you are concerned about your child's condition, or if **any** of the following symptoms occur, your child should be evaluated by a doctor or taken to a clinic or hospital immediately.

SYMPTOMS TO LOOK FOR REGARDING A HEAD INJURY

1. If a headache develops, continues or becomes severe.
2. If vomiting occurs, or if your child complains of dizziness.
3. If sleepiness or drowsiness develops at a time other than normal for sleep.
4. If blood or other fluid drains from the ears or nose.
5. If a seizure or convulsion occurs.
6. If unusual, abnormal behavior, eye movements or unequal pupils occur.
7. Confusion.
8. Avoid giving any medication without first consulting with a doctor.

If you have any additional questions regarding the above, please contact your doctor or an emergency room doctor.

 School Nurse Health Service Assistant

Health Office Phone Number

RETURN TO LEARN

Concussion School Care Plan – MUST be completed by student's physician

This form is adapted from the Acute Concussion Evaluation (ACE) care plan on the CDC web site (www.cdc.gov/injury). All medical providers are encouraged to review this site if they have questions regarding the latest information on the evaluation and care of the scholastic athlete following a concussion injury.

Student Name: _____ Date of Birth: _____

Date of Injury: _____ Date of Evaluation: _____

The above student requires the following short term academic supports for proper concussion management in school (check all items that apply):

- Initial evaluation reveals no evidence of a concussion. Cleared for full academic and athletic activities.**

- Student does have a concussion.**
 - No School or school academic activities at this time.
 - Student may return to school with a reduced academic workload and **NO athletic activities**. (Check all appropriate academic restrictions that apply):
 - Shortened day - Recommend _____ hours per day or as tolerated.
 - Shortened classes (i.e., rest breaks during classes).
 - Maximum class length: _____ minutes or as tolerated.
 - Allow extra time to complete coursework/assignments and tests.
 - Allow 4-6 weeks to make-up any missing assignments or tests, and some assignments need to be forgiven (consult with counselor as necessary).
 - Lessen homework load by _____%.
 - Maximum length of nightly homework: _____ minutes or as tolerated.
 - No classroom or standardized testing at this time.
 - Take rest breaks during the day as needed.
 - Student needs to be allowed to leave the classroom if symptoms are developing or worsening and he/she needs a quiet place to rest (like the nurse's office). If symptoms do not improve, he/she needs to go home.
- Concussion resolved. Student is cleared for full academic participation, allowing 4-6 weeks to make-up any missed work. Student is monitoring self for relapsing symptoms.**
- Student is cleared to begin the Return to Play Protocol, but if the symptoms return, stop the protocol and follow up with your primary care provider.**

- Prolonged Symptoms/Illness: Request meeting of 504 or School Management. 504 team to discuss plan and necessary academic supports.**

Date of Next Evaluation: _____

Medical Office Information (Please Print/Stamp)

Physician Name: _____

Physician Signature: _____

Physician Office Phone: _____

Office Address: _____