



Head Bump Injury Report

Student Name: _____ Date: _____

School: _____ Teacher/Grade: _____

Where and How Injury Occurred: _____

_____ Appearance of injury: _____

SIGNS OBSERVED AND SYMPTOMS REPORTED: _____	Time admitted to Health Room
<i>(symptoms assessed upon entering health room)</i>	
<input type="checkbox"/> _yes_ <input type="checkbox"/> _no Loss of consciousness (at time of injury)	<input type="checkbox"/> _yes_ <input type="checkbox"/> _no Headache or pressure in head
<input type="checkbox"/> _yes_ <input type="checkbox"/> _no Confused or disoriented	<input type="checkbox"/> _yes_ <input type="checkbox"/> _no Nausea or vomiting
<input type="checkbox"/> _yes_ <input type="checkbox"/> _no Answers questions slowly	<input type="checkbox"/> _yes_ <input type="checkbox"/> _no Blurred or double vision
<input type="checkbox"/> _yes_ <input type="checkbox"/> _no Uncoordinated or more clumsy than usual	<input type="checkbox"/> _yes_ <input type="checkbox"/> _no Sensitivity to light or noise
<input type="checkbox"/> _yes_ <input type="checkbox"/> _no Dizzy	<input type="checkbox"/> _yes_ <input type="checkbox"/> _no Unable to recall events <i>before</i> injury
<input type="checkbox"/> _yes_ <input type="checkbox"/> _no Does not “feel right”	<input type="checkbox"/> _yes_ <input type="checkbox"/> _no Unable to recall events during or <i>after</i> injury
<input type="checkbox"/> Other _____	
<i>(including changes in symptoms over time)</i>	
TREATMENT:	
<input type="checkbox"/> Ice	<input type="checkbox"/> Bump washed and bandaged
<input type="checkbox"/> Observation	<input type="checkbox"/> Nurse Assessment
<input type="checkbox"/> Wrist Band (Elementary students only)	<input type="checkbox"/> Other _____
FOLLOWING TREATMENT:	
	Time checked out of Health Room
Parent Notification:	
<input type="checkbox"/> spoke with parent _____	<input type="checkbox"/> Student returned to class
<input type="checkbox"/> unable to contact parent	<input type="checkbox"/> Student sent home
<input type="checkbox"/> message left at _____ (number)	<input type="checkbox"/> Released to EMS
<input type="checkbox"/> 911 called	<input type="checkbox"/> Other _____

Injury witnessed by: _____

Student assisted in health room by: _____

Important: *Due to the inconsistent nature of head injuries, children who have received even what is seemingly a slight bump on the head should be closely observed for at least 24 hours after the incident occurs. Signs and symptoms of a concussion can show up right after the injury or may not appear until days or weeks after the injury.*

Dear Parent:

Today, while at school, your child received an accidental bump, jolt, or hit to his/her head and/or neck.

If your child reports any of the above listed symptoms:

1. **Seek medical attention right away.** A health care professional will be able to determine if your child has had a concussion, how serious it is, and when it is safe for your child to return to normal activities.
2. **Keep your child out of play.** Concussions take time to heal. Don't let your child return to sports or PE until a health care professional says it is okay. Children who return to play too soon—while their brain is still healing—risk a second injury which could be much more serious.
3. **If your child is diagnosed with a concussion, written instruction from a Health Care Provider is needed for them to return to school.** A doctor's note or the *Return After Concussion* form, from the district web site, may be used. (On RSD website see District Departments/Health Services— forms at the bottom of page)

Note: *Parents and their doctor are responsible to determine when a student is fit to return to normal activities. The school may ask for a doctor's note following a head injury/concussion for a student to return to full participation.*

CC: [] Parent [] Health Room File [] School Nurse [] Athletic Director (secondary only)