

STUDENT HEAD HIT OR HEAD INJURY



Important Information from the School Clinic

Student Name _____ Grade _____
 School _____ Clinic Aide _____ Date _____

Dear Parent/Guardian:

You were contacted today because your student experienced a head hit or head injury at school.

*Observe your student closely today and for the next several weeks.
 Always contact your healthcare provider with questions or concerns regarding your student's health.*

<i>PHYSICAL</i>	<i>COGNITIVE</i>
Headache/Pressure Blurred vision Dizziness or Tingling Poor balance Ringing in ears Seeing "stars" Vacant stare	Nausea, vomiting Sensitive to light Numbness, Disorientation Sensitive to noise Neck Pain Glassy eyed
<i>Emotional</i>	<i>MAINTENANCE</i>
Feeling more "emotional" Personality changes Nervous/anxious Irritability Sadness Lack of motivation	Fatigue Drowsiness Sleeping more than usual Sleeping less than usual Trouble falling asleep

Seek Immediate Medical Attention

- Loss of consciousness.
- Seizure or convulsion.
- Confusion, restlessness, or agitation.
- Weakness, numbness, or decreased coordination.
- Repeated vomiting or nausea.
- Slurred speech.
- A child who will not stop crying or cannot be consoled.
- Headaches that do not go away.