Howards Grove School District

403 Audubon Road
Howards Grove, WI 53083

Telephone (920) 565-4454
Fax (920) 565-4461

Head Injury Report

School _____ Date _____

Dear Parent,

Today _____ received an injury to the head. Time occurred: _____
(student name)

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:

1. Confusion or drowsiness.
2. Nausea and/or vomiting.
3. Severe headache or worsening headache.
4. Pupils of different sizes, double vision, blurred vision or loss of vision.
5. Irritability, personality changes or unusual behavior.
6. Weakness or inability to walk.
7. Seizures
8. Bleeding or discharge from ear, nose or mouth.
9. Slurred speech or loss of speech.

Signature: _____ Date _____

Print Name _____

RN Initial/Date
_____

Principal Initial/Date
_____

District Office Initial/Date
_____

Copy of this form to Student's Parent/Guardian
Forward this form with Incident report to Building Principal & District Nurse to Review & District Office if applicable

2/21/JP/HealthServices/Headinjuryreport