Valley School District No. 070
3030 Huffman Road • Valley, WA 99181 • Ph: (509) 937-2791 • Fax: (509) 937-2204 • www.valleysd.org

Head Injury Report

To Parents/Guardians

Date: _____

Dear _____,

Your child received a minor bump or blow to his/her head during school activities today. Please review the following report and the enclosed Concussion Fact Sheet carefully, and continue monitoring your child for further symptoms that may indicate a more serious health condition.

Student Name_____ **School** _____ **Grade**_____

Brief description of incident: _____

_____

_____

_____

Time of injury:_____ **Location of injury on head:** _____

Your student was examined by staff and monitored. Your child experienced:	After the incident, your child:
☐ paleness ☐ headache/pressure ☐ nausea ☐ vomiting ☐ swelling at the site ☐ neck pain ☐ dizziness ☐ disorientation ☐ bruising ☐ minor abrasion/cut ☐ fatigue ☐ numbness/tingling	☐ felt well and returned to class/activities ☐ rested for a period in the healthcare room before returning to class/activities ☐ was released early from school with an authorized guardian

If your child experiences any indicators of concussion in the next few days/weeks, please contact your licensed healthcare provider for further examination as soon as possible.

THINKING/REMEMBERING	PHYSICAL SYMPTOMS	EMOTIONAL/MOOD	SLEEP PATTERNS
Difficulty thinking clearly, confused	Worsening headache; vision changes (fuzzy, blurry, double)	Irritability	Sleeping more than usual
Feeling sluggish, slowed down, dazed	Repeated nausea, vomiting; dizziness, decreased coordination	Personality or behavior changes	Sleeping less than usual
Difficulty concentrating	Sensitivity to light, noise	More emotional	Trouble falling asleep
Difficulty remembering new information	Feeling tired, drowsy; no energy	Nervousness or anxiety	

Please contact me at the school office if you have any further questions or concerns.

Staff Name/Title: _____Phone No.: _____

Signature: _____