ARLINGTON PUBLIC SCHOOLS
EDUCATE • PREPARE • INSPIRE

315 N French Ave
Arlington, WA 98223
360-618-6200

# HEAD INJURY NOTIFICATION

Dear Parent/Guardian:

Date: _____

_____ (Student Name) received an injury to his/her head today at _____ ☐ AM ☐ PM

How injury occurred: _____

Location: ☐ Class ☐ Playground ☐ Gym ☐ Laboratory ☐ Shop ☐ Off-Premises Other _____

We had him/her rest and we observed him/her for signs of brain concussion.

At this time there were: ☐ No obvious signs of head injury ☐ Signs of possible head injury*

*Comment: _____

*Your child had:

☐ Swelling at the site of injury ☐ Headache

☐ Other _____

Disposition:

☐ Student felt well and returned to class/activities
☐ Student sent home with parent

Time Parent was called _____ Time Aid Unit was called _____

Comments: _____

Parent /Guardian _____

Phone ___ - ___ - ___ Cell Phone ___ - ___ - ___

Address _____

***In the event that your child experiences any of the symptoms below, please seek medical attention:***

~ Loss of consciousness
~ Weakness or paralysis of face or limbs
~ Blood or clear fluid draining from ears or nose
~ Convulsions
~ Eye changes: loss of vision, unequal pupils, double vision, blurred vision
~ Rise in temperature
~ Nausea or vomiting
~ Dizziness or sleepiness
~ Paleness or flushing
~ Confusion or memory loss
~ Slowing of pulse
~ Stiffness of neck

Sincerely,

_____ Name

_____ Title

_____ School

___ - ___ - ___ Phone Number