



**FRAMINGHAM PUBLIC SCHOOLS**  
**School Health Services**  
**REPORT TO PARENTS OF HEAD INJURY**

Date: \_\_\_\_\_

Time of Injury: \_\_\_\_\_

Dear Parent/Guardian:

As you have been informed your son/daughter, \_\_\_\_\_ received an injury to the head.

Listed below are some signs and symptoms which may occur in the next 48 hours, that may require attention from a physician.

Observe your child with these guidelines for the next 48 hours:

1. Inability to be awakened to fully alert status, (check every hour for 8 hours after injury)
2. Continued headache, (minimal to severe)
3. Vomiting and nausea more than once or beginning again hours after it ceased
4. Double vision, blurred vision, or pupils of unequal size
5. Any unusual symptoms such as, dizziness, irritability, confusion, slurred speech, stiff neck and weakness in arms or legs
6. Seizures (convulsions) place child on side where he/she cannot fall
7. Blood or clear fluid dripping from ears or nose, (do not blow a bloody nose or attempt to clean blood from ears or nose)

\_\_\_\_\_  
Your School Nurse

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Please sign and return this portion to the school nurse when child returns to school. Thank you.

\_\_\_\_\_  
Students Name

\_\_\_\_\_  
School

**COMMENTS:** (to include symptoms, follow-up and findings)

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date