THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

DATE _____

SCHOOL _____

ROOM/BOOK _____

Dear Parent/Guardian:

Today, at_____ o'clock, your child _____experienced an injury to the head. He/she was kept in the health room for _____ minutes in order to be observed for symptoms of a serious head injury, after which he/she returned to the classroom. One hour later he/she was seen again in the health room to assess his/her condition. No symptoms have been displayed. Please consult your family physician or take your child to a hospital immediately if any of the symptoms listed below occur:

- Change in behavior, i.e., confusion, irritability
- Dizziness, nausea, vomiting (more than 2 times)
- Convulsion
- Blurred vision or abnormal eye movements
- Severe headaches
- Paralysis of arms and/or legs
- Extreme continued drowsiness
- Staggering gait

Please ask your doctor to complete the back of this form and return it to the School Nurse as soon as possible. If a physician has not seen your child, please explain reason on the back and return it to the School Nurse.

In any case, even if these symptoms do not develop, you may wish to consult your family physician.

_____

SCHOOL NURSE

REPORT BY FAMILY DOCTOR

DIAGNOSIS:

TREATMENT:

SPECIFIC INSTRUCTIONS FOR HOME/SCHOOL:

DATE OF FOLLOW-UP VISIT: _____

_____ _____

DOCTOR'S SIGNATURE DATE SIGNED

_____ _____

DOCTOR'S PRINTED NAME PHONE NUMBER

REPORT BY PARENT/GUARDIAN

_____ _____

PARENT'S SIGNATURE DATE SIGNED