CORNWALL-LEBANON SCHOOL DISTRICT
105 E. EVERGREEN ROAD
LEBANON, PA 17042
Health Services Department

HEAD TRAUMA CHECKLIST

Dear Parent:

Today, _____, your child, _____ received an injury to the head. Your child was seen by the building nurse and had no difficulty at that time, but you should observe for any of the following symptoms. Should any of these **symptoms occur or worsen,** contact your child's physician or take your child to the emergency room for an evaluation.

Symptoms occurring or worsening:

- Headache, dizziness
- Nausea/vomiting
- Personality, behavior changes or other changes that do not seem normal for your child
- Seizure, staring into space, trouble speaking
- Blurred vision, double vision, pupils of different sizes
- Loss of muscle coordination or tone, weakness, tremors, loss of balance, difficulty walking
- Pain in head, ear, jaw, temperature changes, sensory changes, hearing loss, ears ring

If the nurse contacted you regarding the injury, you do not need to return the tear off portion of this form to school. If she has not contacted you because the injury appeared minor, please sign the form below and send it back to school with your child to verify that you have received this checklist.

Symptoms may be immediate or delayed. The head injury can be serious even if there is not a visble mark or bruise. Again, please contact your child's physician should you have any concerns about the injury.

If you have any questions, please contact your building nurse.

_____

Student's Name_____ Teacher/Homeroom_____

Date of injury_____Parent Signature_____