CUSD
NURSING SERVICES

CLOVIS UNIFIED SCHOOL DISTRICT

NOTIFICATION OF A HEAD INJURY

To the Parents/Guardian of: _____ Date: _____

Your child sustained a head injury at school today. A brief description of how the injury occurred is:

_____

_____

At present, he/she is exhibiting these signs and/or symptoms:

- ☐ Headache or "pressure" in head
- ☐ Dizziness
- ☐ Nausea
- ☐ Vomiting
- ☐ Light sensitivity
- ☐ Noise sensitivity
- ☐ Bump or Swelling
- ☐ Bruising
- ☐ Cut
- ☐ Bleeding/drainage from ears and/or nose
- ☐ Slurred speech
- ☐ Slow to answer questions
- ☐ Difficulty with coordination or balance
- ☐ Abnormal behavior; nervousness, anxiety, or perseveration.
- ☐ Unequal pupil size or reaction to light
- ☐ Blurred vision, seeing stars, double vision, and/or sensitivity to light
- ☐ Confusion
- ☐ Loss of memory
- ☐ Loss of consciousness or responsiveness
- ☐ Sleepiness/Drowsy
- ☐ Numbness or tingling
- ☐ Emotional
- ☐ Seizure
- ☐ Other _____
- ☐ None

Head injuries can occasionally cause trouble many hours or days later. The symptoms may last only a few minutes or for several months. If you are concerned about your child's condition, or if **any** of the following symptoms occur, your child should be evaluated by a doctor or taken to a clinic or hospital immediately.

SYMPTOMS TO LOOK FOR REGARDING A HEAD INJURY

1. If a headache develops, continues, or becomes severe.
2. If vomiting occurs, or if your child complains of dizziness.
3. If sleepiness or drowsiness develops at a time other than normal for sleep.
4. If blood or other fluid drains from the ears or nose.
5. If a seizure or convulsion occurs.
6. If unusual, abnormal behavior, eye movements or unequal pupils occur.
7. Confusion.
8. Avoid giving any medication without first consulting with a doctor.

If you have any additional questions regarding the above, please contact your doctor or an emergency room doctor.

_____ _____

☐ School Nurse ☐ Health Service Assistant Health Office Phone Number

CLOVIS UNIFIED SCHOOL DISTRICT

RETURN TO LEARN

Concussion School Care Plan – MUST be completed by student's physician

This form is adapted from the Acute Concussion Evaluation (ACE) care plan on the CDC web site (www.cdc.gov/injury). All medical providers are encouraged to review this site if they have questions regarding the latest information on the evaluation and care of the scholastic athlete following a concussion injury.

Student Name: _____ Date of Birth: _____

Date of Injury: _____ Date of Evaluation: _____

The above student requires the following short-term academic supports for proper concussion management in school (check all items that apply):

☐ **Initial evaluation reveals no evidence of a concussion. Cleared for full academic and athletic activities.**

☐ **Student does have a concussion.**

☐ No School or school academic activities at this time.

☐ Student may return to school with a reduced academic workload and **NO athletic activities**. (Check all appropriate academic restrictions that apply):

☐ Shortened day - Recommend _____ hours per day **or** ☐as tolerated.

☐ Shortened classes (i.e., rest breaks during classes).

☐ Maximum class length: _____minutes **or** ☐as tolerated.

☐ Allow extra time to complete coursework/assignments and tests.

☐ Allow 4-6 weeks to make-up any missing assignments or tests, consider forgiving assignments as able (student to consult with counselor/teacher).

☐ Lessen homework load by _____%.

☐ Maximum length of nightly homework: _____ minutes **or** ☐as tolerated.

☐ No classroom or standardized testing at this time.

☐ Take rest breaks during the day as needed.

☐ Student needs to be allowed to leave the classroom if symptoms are developing or worsening and he/she needs a quiet place to rest (like the nurse's office). If symptoms do not improve, he/she needs to go home.

☐ **Concussion resolved. Student is cleared for full academic participation**, allowing 4-6 weeks to make-up any missed work. Student is monitoring self for relapsing symptoms.

☐ **Student is cleared to begin the Return to Play Protocol**, but if the symptoms return, stop the protocol and follow up with your primary care provider.

☐ Prolonged Symptoms/Illness: Request meeting of 504 or School Management. 504 team to discuss plan and necessary academic supports.

Date of Next Evaluation: _____

Medical Office Information (Please Print/Stamp)

Physician Name: _____

Physician Signature: _____

Physician Office Phone/Address: _____