IUSD HEALTH SERVICES

HEAD INJURY NOTIFICATION

Stu #	Student's Name	DOB	M/F	School	Grade

Date: ____________________ Completed by: ________________________________

School Nurse Health Aide School Clerk

Today your child sustained an injury to the head and was seen in the health office.

The cause of the injury was: ________________________________

The following symptoms were observed: ________________________________

☐ We contacted you by telephone. ☐ We were unable to reach you.
☐ A message was left for you. ☐ Other: ________________________________

Because symptoms can develop following a head injury, even after time has lapsed, you should be alert to any of the following symptoms:

- Nausea and/or vomiting; slow or difficult breathing
- Complaint of severe headache or dizziness, loss of consciousness, or convulsions
- Excessive drowsiness (wake your child every 2-3 hours during the night to check)
- Double vision, blurred vision, one pupil being smaller or larger than the other, sensitivity to light or noise
- Muscle weakness or lack of coordination such as falling down, stumbling, or walking strangely
- Confusion, memory loss, or changes in mood, behavior or personality
- Bleeding or clear discharge from the ear, nose, or mouth

Contact your doctor or the emergency room immediately if you notice any of the above symptoms.
If your child is seen by a health care professional it is required by law, Education Code AB 25, that the examiner complete the bottom portion of this form, then return the entire form to the school health office. If you have any questions or need assistance in locating a health care provider, please contact the health office at 949-936- .

, RN	, Irvine, CA 92	@iusd.org
School Nurse	School Address	email

PARENT PERMISSION FOR PHYSICIAN RELEASE OF INFORMATION

As the parent or legal guardian of the above named student, my signature authorizes Irvine Unified School district and the physician(s) identified below to release and exchange medical information relative to the above named student. I certify that I am aware of my right to review any requested records and receive a copy of any materials forwarded.

Parent/Guardian signature: ________________________________ Date: ____________

PHYSICIAN'S REPORT OF EXAMINATION

Results may be faxed to the school at 949-936- .

Diagnosis: ________________________________

Treatment Plan: ________________________________

____

Restrictions and duration: ________________________________

____

Student may return to school on: ________________________________

Examiner's Name Date

Address

Phone Number Fax

Office Stamp

Revised 04-21-2016