Woburn Public Schools
Health Services

Head Injury Referral

Dear Parent /Guardian, Date:

Your child, _____, sustained a head injury today. Signs and symptoms checked below indicate that a concussion may have occurred. **Due to the seriousness of these symptoms, it is strongly recommended that your child be evaluated by your primary care provider or emergency services.**

Signs Observed

- o Appears dazed or stunned
- o Pupils different sizes or not reacting equally to light stimulus
- o Drowsiness and confusion/behavior changes
- o Change in physical coordination or gait
- o Answers questions slowly
- o Other _____

Symptoms Reported by Student

- o Headache or pressure in the head
- o Nausea/vomiting
- o Balance problems or dizziness
- o Double or fuzzy vision
- o Sensitivity to light or noise
- o Feeling sluggish or slowed down
- o Feeling foggy or groggy
- o Does not feel right
- o Can't recall events prior to and /or after injury

Description of incident_____

_____

Concussion history_____

_____

Please have your health care provider complete the form on the reverse side of this page and return it to the school nurse so that we may best serve the needs of your child in school.

Sincerely,

_____ Phone: _____ Fax: _____

The Woburn Public Schools have enacted head injury guidelines supervised by our school nurses. In order to help facilitate the student's recovery from a potential concussion, please complete the following:

Student name: _____

Date of exam: _____

Diagnosis: _____

Plan:

- o No restrictions
- o Restrictions: (Please Circle)

Physical: work, stairs, gym, sports, recess

Cognitive: academic accommodations

Accommodations will be arranged by the school nurses and staff as needed.

Duration: _____

Follow up: _____

Specialty referral (if any):_____

Diagnostic tests ordered (if any): _____

Physician
Signature: _____ Date: _____

Address: _____ Phone: _____

Please call the school nurse with any questions or concerns.

Name: _____ Phone Number: _____ Fax: _____

Revised 6/2011