MUHLENBERG SCHOOL DISTRICT
HEALTH SERVICES

NOTIFICATION OF HEAD INJURY

Date:_____
Dear Parent/Guardian:

Your child, _____ sustained an injury to the head.

This student is having the following signs and symptoms:

_____

_____

As per Muhlenberg School District concussion protocol, your child was evaluated and monitored frequently throughout the school day by the school nurse. Please continue to monitor your child closely for at least the next 24 hours for any of the following symptoms:

- Severe headache
- Nausea/vomiting
- Double vision, blurred vision, or pupils of different sizes
- Loss of muscle coordination, such as falling down, walking strangely or staggering
- Any unusual behavior such as being confused, breathing irregularly or dizziness
- Convulsion (seizure, fit)

***IMMEDIATELY CONTACT YOUR DOCTOR OR TAKE YOUR CHILD TO THE EMERGENCY ROOM** if your child shows any of the above symptoms.

***CALL 911 if your child becomes unresponsive or has a seizure.**

***Please take the attached *Concussion Guideline* form to be completed by your health care provider. Return this form to the school nurse.

School Nurse

NOTE: <u>Student should not take pain medicine</u> such as Ibuprofen, Advil, Motrin, Aleve or Naproxen **<u>for the next 48-72 hours</u>** *unless a medical provider says the student can take this***.**

DISTRITO ESCOLAR MUHLENBERG
SERVICIOS DE SALUD
NOTIFICACIÓN DE LESIÓN EN LA CABEZA

Fecha: _____

Estimado Padre / Guardián:

Su niño/a, _____ ha sostenido una concusión en la cabeza el día de hoy la escuela. Según el protocolo de concusión cerebral del Distrito Escolar de Muhlenberg, su hijo/a fue evaluado y monitoreado con frecuencia durante el día escolar por la enfermera de la escuela. Por favor, continúe monitoreando de cerca a su hijo/a durante las próximas 24 horas por cualquiera de los siguientes síntomas:

- Dolor de Cabeza Intenso
- Náuseas Vómitos
- La visión doble, visión borrosa, o pupilas de diferentes tamaños
- La pérdida de la coordinación muscular, como caerse, caminar de manera extraña o escalonamiento
- Cualquier comportamiento inusual como estar confundido, respiración irregular o mareos
- Convulsión (procesos epilépticos)

*** CONTACTE A SU MÉDICO O LLEVE AL NIÑO/A AL SERVICIO DE URGENCIAS** si su niño/a muestra cualquiera de los síntomas anteriores.

*** LLAME AL 911** si su hijo/a deja de responder o tiene una convulsión**.**

***** Por favor, tome el formulario de *Orientación Concusión* adjunta para ser completado por el médico. Devolver este formulario a la enfermera de la escuela.

Enfermera Escolar

Muhlenberg School District
Health Services Department
Concussion Guidelines for Educators

Student Name: _____ DOB: _____

Date of evaluation: _____ Date of Injury:_____

☐ **No concussion present** - student may participate in full academic activity, physical education and sports participation

☐ **Concussion resolved** - may return to all normal academic and physical activity without restrictions.

☐ **Diagnosis of concussion:**

Until this student is fully recovered, the following supports are recommended: *(check all that apply)*

__ No return to school until **(date) _____** .

__Return to school with following supports:

__ Shortened day: half days by alternating AM and PM attendance.

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

__ Lessen homework load.

__ No homework or major projects.

__ No significant classroom testing/quizzes or standardized testing at this time.

__ Untimed tests and quizzes allowed.

__ No band, orchesta, chorus or music classes to include extracurricular school activities, i.e. marching band, school musical practice/performance.

__ Computer work and screen time as tolerated with scheduled breaks

__ No computer/screen time allowed

__ No physical education class/sports until further notice

___ May do low levels of non-contact physical activity. This includes walking, light jogging, light stationary biking, and light weightlifting (lower weight, higher reps, no bench, no squat). Student should stop if symptoms worsen.

___ **Gradual** return to sports practices under the supervision of an appropriate health care provider (e.g., athletic trainer or certified school nurse).

__ May resume full academic activity, which is to be made up gradually over 10 school days.

Follow up Appointment date: **_____**

Health Care Provider Signature: _____ Name of Practice Group:_____

Health Care Provider (Please Print):_____ License#:_____

Phone #:_____ Fax#:_____

*****THIS NOTE WILL BE IN EFFECT UNTIL STUDENT RECEIVES MEDICAL PROVIDER CLEARANCE and UPDATED FORM*****