SHAWANO SCHOOL DISTRICT

HEAD INJURY REPORT

PARTICIPANT/PARENTS

COMMUNITY GROUPS USING FACILITIES

Date of incident: _____

Time: _____ a.m. p.m.

School: _____

PARENT: This is to inform you that your child, _____ has suffered a head injury.

ADULT PARTICIPANT: Since you have received a head injury while participating in an activity at one of the buildings at the Shawano School District we would like to make you aware of some conditions that may appear after a head injury.

Listed below are some symptoms which may occur and may require immediate attention from a physician. If any of these conditions become apparent, please consult your physician at once for instructions or recommendations he/she may have in this matter:

1. Weakness of either arm or leg
2. Vomiting
3. Increasing drowsiness
4. Slowing of pulse
5. Continued headache
6. Stiffness of neck
7. Blood or clear fluid dripping from ears or nose
8. Convulsions - seizures
9. A rise in temperature

To confirm that you received the above information please sign and date at the bottom of this form.

Sandi Kane, Director
Shawano Community Education Office
Shawano School District

Please Sign & Return this form to the Community Education Office within 24 hours of incident.

Shawano Community Middle School, % Sandi Kane, 1050 S Union Street, Room 102, Shawano, WI 54166
715.526.2192 x3102 Fax 715.524.1070 kanes1@shawanoschools.com

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Signature of Parent/Participant Date