Killeen Independent School District
P.O. Box 967•200 North W.S. Young Drive•Killeen, Texas 76540-0967
254/336-0000

Head Injury Declination for Medical Attention

I,_____, the parent of, _____ (child's name) received notice that my child sustained an injury to the head. My child was seen in the clinic and it is recommended for them to follow up with a provider who has concussion experience. I was alerted to watch for any of the following symptoms:

1. severe headache
2. excessive drowsiness (awake the child at least twice during the night)
3. nausea and/or vomiting
4. double vision, blurred vision, or pupils of different sizes
5. loss of muscle coordination such as falling down, walking strangely, or staggering
6. any unusual behavior such as being confused, breathing irregularly, or being dizzy
7. convulsion
8. bleeding or discharge from an ear
9. slurred speech

At this time, I do NOT wish to seek further medical attention for my child. In doing this, I understand they will remain out of play activities for 48 hours from the head injury event.

I also understand that if my child develops any of the symptoms listed above within 48 hours they will be excluded from school until they have been evaluated by a medical professional and have a "return to play" doctor's note.

Date of Incident:_____ Time of Incident:_____

_____
Parent Signature

_____
Telephone Number

White copy – Clinic Yellow copy – Parent