

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
Health Services Office
BUMPS OR BLOWES ON THE HEAD

Date _____ School _____ Room _____

Dear Parent:

_____ received a bump or blow on his/her head on the
_____ VWXGHQW¶V QDPH

_____ by _____
(exact area) (describe accident, distance of fall, etc.)

_____ at _____