

DELAWARE CITY SCHOOLS
248 North Washington Street
Delaware, Ohio 43015

Date: _____ Time: _____

Student's Name

_____ received a head bump*

_____ fell

_____ received a cut

_____ Nose bleed

_____ bee/insect sting

_____ Other _____

This injury seemed minor, but you will want to check it.

***Please check carefully for complaints of severe headache, nausea, blurred vision or drowsiness. Symptoms of head injuries may develop slowly and a child should be observed for at least 24 hours.**

Staff Member

Title

School