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
V W X G H Q W ¶ V Q D P H

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

_____ at ____