MANHASSET SECONDARY SCHOOLS
HEALTH OFFICE

POST-CONCUSSION CLEARANCE

FORM I

Patient Name: ___________________________ Grade: ___

Date of Evaluation: ____________________________________

The athlete named above is cleared for a complete return to:

- **Full Contact** Sport Participation as of : __________________
- **Limited Contact** Sport Participation as of : __________________
- **Strenous Non-Contact** Sport Participation as of: ________________
- **Non-Strenous Non-contact** Sport Participation as of: ___________

The athlete is instructed to stop play immediately and notify the coach or athletic trainer should his/her symptoms return.

Private Physician's Signature: __________________________

Physician's Stamp:

Chief School Physician: ___________________________________

200 MEMORIAL PLACE • MANHASSET, NEW YORK • 11030
PHONE: (516) 267-7520 • FAX: (516) 267-7524