

MANHASSET SECONDARY SCHOOLS HEALTH OFFICE

Post- Concussion Evaluation Sheet From Private Physician

Name: _____ **Grade:** _____ **Date of Birth:** _____
Address: _____ **Date of injury:** _____

SCHOOL ATTENDANCE:

No Restrictions
Full Days as tolerated
Half Days as tolerated
No school – Home school/tutor
No school – Rest only
Other

CLINIC FOLLOW-UP:

None-Cleared
One week
Two weeks
____ weeks
Extended Testing
When Asymptomatic @ rest
Other

ACADEMIC ACCOMODATIONS:

Untimed tests and assignments
Reduced workload
Allow Frequent breaks
Provide outline of class notes
Obtain notes from peers
Tutoring as needed
Other

TREATMENT RECOMMENDATIONS:

Cog Rehab
CT/MRI/EEG
Psychotherapy
Psychiatry
Neurology/Headache Clinic
PT/Ortho
Balance Clinic
Support Group
Other

GYM/RECESS:

No gym or recess

EXERTION:

None until next visit
None until _____ then light if asx
Light until _____ then mod if asx
Mod until _____ then heavy if asx
Progress L/M/H through L/M/H over next
_____ days/weeks

PRIVATE PHYSICIAN SIGNATURE: _____
DATE: _____
STAMP: _____