



Manhasset Public Schools

Health Offices

Dear Parent/Guardian:

New York State Education Policy requires that any student athlete who exhibits signs, symptoms, or behaviors consistent with a concussion, be removed from sports and shall not return to play until cleared by an appropriate health-care professional. Your child's recent medical history indicates that he/she sustained an injury meeting these criteria. New York State permits only the school medical officer to clear a student athlete to return to play after removal from a game for this type of injury.

Therefore, a request is being made for his/her private health care professional to complete the appropriate attached forms at this time (the 'Evaluation-No Concussion' form, or the Post-Concussion Evaluation Sheet and the 'Post Concussion Clearance Form') and return them to the Secondary School Health Office. If you have any questions, please us call at (516) 267-7520.

Sincerely,

**Jill McCarney, RN, MA
Joann Marcucci, RN, MS, NCSN**

**Dr. Roselia Guillen-Santana
Dr. Ronald Marino
Medical Directors, Manhasset Public Schools**



Manhasset Public Schools

Health Offices

Secondary School

EVALUATION – NO CONCUSSION

Patient Name: _____

Date of Evaluation: _____

The student athlete named above did not show any symptoms of a concussion and therefore does not have a concussion.

****This form is only filled out if the student athlete DID NOT sustain a concussion****

Primary Physician's Signature: _____

Physician's Stamp:

Secondary School Health Office

200 Memorial Place
Manhasset, NY 11030

Phone: 516-267-7520

Fax: 516-267-7524

REVISED 5/2021



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SECONDARY SCHOOL Post- Concussion Evaluation Sheet From Primary 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

PRIMARY PHYSICIAN SIGNATURE: _____

DATE: _____ **STAMP:** _____

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Revised 5/2021



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POST-CONCUSSION

CLEARANCE FORM

Patient Name: _____ Grade: _____

Date of Evaluation: _____

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

- **Full Contact** Sport Participation which includes **Full Academic** participation with no accommodations as of: _____
- **Limited Contact** Sport Participation as of: _____
- **Strenuous Non-Contact** Sport Participation as of: _____
- **Non-Strenuous Non-Contact** Sport Participation as of: _____

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

Primary Physician's Signature: _____

Physician's Stamp:

School District Medical Director: _____

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