Manhasset Public Schools

Health Offices

Elementary School

POST-CONCUSSION CLEARANCE

FORM II

STUDENT– LIMITED CONTACT

Patient Name:_____

Date of Evaluation: _____

The student named above is cleared for a complete return to **limited contact*** physical education participation as of _____. The student is instructed to stop play immediately and notify the nurse should his/her symptoms return.

Private Physician's Signature:_____

School District Medical Director:_____

*Another evaluation may be needed in the future if full contact is not approved at this time.

Shelter Rock Health Office
27A Shelter Rock Road
Manhasset, NY 11030

Phone: 516-267-7460
Fax: 516-267-7462
SRHealthOffice@manhassetschools.org

Munsey Park Health Office
1 Hunt Lane
Manhasset, NY 11030

Phone: 516-267-7410
Fax: 516-267-7489
MPHealthOffice@manhassetschools.org

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