Manhasset Public Schools

Health Offices

Elementary School
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:**

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