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 a 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 call us at (516) 267-7520 or e-mail us at SSHealthOffice@manhassetschools.org.

Sincerely,

Christina Kalamotousakis, RN, MS, PNP
Yeanah Kim, RN, BSN, CPN

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

Manhasset Secondary School – 200 Memorial Place, Manhasset, NY 11030
Phone: 516-267-7520 Fax: 516-267-7524
E-mail: SSHealthOffice@manhassetschools.org

Revised 10/2024

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
E-mail: SSHealthOffice@manhassetschools.org

Manhasset Public Schools

Health Offices

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:**

Manhasset Secondary School – 200 Memorial Place, Manhasset, NY 11030
Phone: 516-267-7520 Fax: 516-267-7524
E-mail: SSHealthOffice@manhassetschools.org

Manhasset Public Schools

Health Offices

Secondary School

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: _____

Secondary School Health Office
200 Memorial Place
Manhasset, NY 11030

Phone: 516-267-7520 / Fax: 516-267-7524
E-mail: SSHealthOffice@manhassetschools.org