Manhasset Public Schools

Health Offices

Dear Parent/Guardian:

New York State Education Policy requires that any student 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. Therefore, a request is being made for his/her private health care professional to complete the appropriate attached forms at this time:

If no concussion after evaluation, physician fills out **"Evaluation-No Concussion" on page 1**

If sustained concussion and needs temporary medical and academic accommodations, the physician fills out **"Post-Concussion Evaluation Sheet" on page 2. Please ensure they include a follow-up date.**

Once cleared of concussion, physician fills out the **"Post-Concussion Clearance Form" on page 3.**

For Student Athletes: If your child plays an interscholastic sport, the physician must ALSO fill out the **"Interscholastic Sports Post-Concussion Clearance Form" on page 4** for your child to start the return-to-play (RTP) process with our Athletic Trainer. Once they've completed **ALL 6 phases of RTP,** they may return to full interscholastic sports participation.

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

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EVALUATION-NO CONCUSSION

Patient Name: _____

Date of Evaluation: _____

The student 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 DID NOT sustain a concussion

Primary Physician's Signature: _____

Physician's Stamp:

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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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POST-CONCUSSION CLEARANCE FORM

Patient Name: _____ Grade: _____

Date of Evaluation: _____

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

- **Full** return to Physical Education participation which includes **Full Academic** participation with no accommodations as of: _____
- **Limited** Physical Education participation as of: _____
- **Strenuous Non-Contact** Physical Education participation as of:_____
- **Non-Strenuous Non-Contact** Physical Education participation as of:_____

The student 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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Interscholastic Sports
Post-Concussion Clearance Form

Student Name _____ Date of Birth _____ Grade _____

Date of Injury _____

❑ **The student IS cleared for GRADUATED RETURN TO PLAY PROTOCOL as of _____**

-Graduated return to play can start after 24 hours free of concussion symptoms
-Protocol is progressive and under the supervision of athletic trainer
-Only one phase is introduced every 24 hours. If symptoms return, will not advance to next phase.

Phase 1- low impact, non-strenuous, light aerobic activity such as walking or riding a stationary bike.
Phase 2- higher impact, higher exertion, and moderate aerobic activity such as running or jumping rope.
Phase 3- Sport specific non-contact activity. Low resistance weight training with a spotter.
Phase 4- Sport specific activity, non-contact drills. Higher resistance weight training with a spotter.
Phase 5- Full contact training drills and intense aerobic activity.
Phase 6- Return to full activities without restrictions.

❑ **The student is NOT cleared for the graduated return to play protocol but may have limited participation with the following restrictions:**

_____

Expected re-evaluation to advance these restrictions on/about: _____

❑ **The student is NOT cleared for the graduated return to play protocol and may NOT return to PE or sports/athletics until further notice.**

Expected re-evaluation to advance these restrictions on/about: _____

Please note, ALL students are required to compete the school-based six phase graduated return to play protocol before full participation in PE or sports/athletics

Health Care Provider Signature _____ Date _____

Printed Name _____ Telephone _____ Fax _____