GENESEO
THE STATE UNIVERSITY OF NEW YORK

CONCUSSION EVALUATION

Student Name:____G00#: ________________

DOB: (/   /   ) Date Concussion Occurred: (/   /   ) Date of Initial Visit:(/   /   )

Please complete all of the sections below:

□ Full mental rest:

□ No class attendance, homework, exams or screen time for____day(s).

□ Partial mental rest/limited mental activity starting on: (/   /   )

□ May attend classes for lecture and discussion only.

□ Limit screen time to minutes at a time, and a total of hours per day.

□ No exams or complex homework assignments.

□ May take exams and return to completing homework.

□ May progress as tolerated.

□ May return to full class schedule and activityby: (/   /   )

□ Other

□ No further evaluation needed **OR** □ Next follow upappointment: (/   /   )

I give permission to the staff of the Office of Disability Services (ODS) at SUNY Geneseo to communicate as needed with instructors (Faculty, Associate instructors, and/or course supervisors).

Student Signature**:**____
Date:__________________Phone:____

I have evaluated the above named student. The recommendations relate to return to daily activities and academics.

Provider (printed): Date:
Signature:

Office of Disability Services· SUNY Geneseo· 1 College Circle, Erwin 22· Geneseo· New York· 14454
Phone: 585.245.5112 FAX: 585.245.5091 Email: (disabilityservices@geneseo.edu),

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Your next step is to visit Disability Services for Students for faculty follow up.

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