Assessment/Release for Return to Play Following COVID-19 Infection

Every student-athlete who has tested positive for COVID-19 must be cleared by an approved healthcare provider.

Patient:_____ School:_____

DOB:_____ Sport:_____

Provider/Practice: _____

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Date of onset of COVID-19 symptoms: _____
Date of resolution of COVID-19 Symptoms: _____
Date of COVID-19 Positive test result: _____

Systemic symptoms for 3 days or more at time of illness (fever, myalgia, chills, profound lethargy)?:	N□	Y□
Hospitalization due to COVID-19 symptoms?:	N□	Y□
History of abnormalities previously followed by cardiology?:	N□	Y□

Symptoms *following* COVID-19 infection:

Chest pain with exertion or exercise?:	N□	Y□
Shortness of breath with minimal activity?:	N□	Y□
Excessive fatigue with activity?:	N□	Y□
New abnormal heartbeat or palpitations?:	N□	Y□
Unexplained fainting or near fainting?:	N□	Y□

Provider Assessment:
Date of exam: _____

Temp:_____Pulse:_____ BP:_____ RR:_____ Oximetry (if indicated): _____

Normal cardiovascular exam?: Y□ N□

□EKG performed □Normal □Abnormal (Cardiology follow up needed)

Cardiology referral indicated?: N□ Y□

□ Athlete was not hospitalized due to COVID-19 infection

Criteria to return (Please check below as applies)

□ 10 days have passed since onset of symptoms
□ No symptoms for 72 hours: no fever >100.4F without antipyretics, no cough or shortness of breath

□ Athlete **HAS** satisfied the above criteria and **IS** cleared to return to activity fully, <u>without</u> the return to play progression
□ Athlete **HAS** satisfied the above criteria and **IS** cleared to return to activity ***<u>with</u>*** return to play progression
□ Athlete **HAS NOT** satisfied the above criteria **IS NOT** cleared to return to activity

MEDICAL OFFICE INFORMATION (PLEASE PRINT OR STAMP):

Evaluator's Name:_____ Evaluator's Address/Phone: _____

Evaluator's Signature:_____ _____