# Adlai E. Stevenson High School Covid-19 Clearance Form

The student below is being released for athletic participation following:

❑ COVID-19 or SARS-CoV-2

Name of Student: _____

DOB: _____ Date of Positive Test: _____

Date of Full Clearance_____ **OR** Date of Clearance to Begin RTP _____

**Criteria to return** (Please check below all that apply)

❑ 10 days have passed since symptoms began
❑ Has been asymptomatic for 10 days from date of COVID-19 test
❑ Symptoms have resolved (No fever (≥100F Temp) for 24 hours without fever reducing medication, improvement of symptoms (cough, shortness of breath)
❑ Student was not hospitalized due to COVID-19 infection.
❑ Cardiac screen negative for myocarditis/myocardial ischemia (All answers below must be no)

| | | | | |
|---|---|---|---|---|
| Chest pain/tightness with exercise | YES | ❑ | NO | ❑ |
| Unexplained Syncope/near syncope | YES | ❑ | NO | ❑ |
| Unexplained/excessive dyspnea/fatigue w/exertion | YES | ❑ | NO | ❑ |
| New palpitations | YES | ❑ | NO | ❑ |
| Heart murmur on exam | YES | ❑ | NO | ❑ |

NOTE: If any cardiac screening question is positive or if the student was hospitalized, consider further workup as indicated. May include CXR, Spirometry, PFTs, Chest CT, Cardiology Consult.

○ Student **HAS** satisfied the above criteria and is cleared to start **without** Return to Play Protocol.
○ Student **HAS** satisfied the above criteria and is cleared to start **after** Return to Play Protocol.
○ Student **DID NOT** satisfy the above criteria and is not cleared to return to activity.

**I clear the above-named student to resume full participation in Athletics/PE following the above diagnosis.**

_____ _____
Signature of Licensed Physician, Licensed Physician Assistant, Licensed Nurse Practitioner — Date

_____
Please Print Name of Licensed Physician, Licensed Physician Assistant, Licensed Nurse Practitioner (Please Circle)

***** If RTP Is Required Please Use on the Bottom of the Next Page*****

# Adlai E. Stevenson High School Covid-19 Clearance Form

## Parent/Legal Custodian Consent

IF a student or athlete has tested positive for COVID-19, they must be cleared back to activity by an approved health care provider preferably with a pediatric background (**MD/DO/PAC/NP**).

- ❑ I acknowledge that the Licensed Health Care Provider listed above has provided medical care to my child.
- ❑ I acknowledge that the Licensed Health Care Provider above has provided clearance to my child to resume full participation or begin Return to Play Protocol.

By signing below, I hereby give my consent for my child to resume full participation to activity at Adlai E. Stevenson High School.

_____ _____

Signature of Parent/Legal Custodian Date

_____

Please Print Name

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## Return to Play (RTP) Protocol After COVID-19 Infection

Students must complete the progression below without development of chest pain, chest tightness, palpitations, lightheadedness, presyncope or syncope. If these symptoms develop, the patient should be referred back to the evaluating provider who signed the form.

- **Stage 1**: (2 Days Minimum) Light Activity (Walking, Jogging, Stationary Bike) for 15 minutes or less at intensity no greater than 70% of maximum heart rate. NO resistance training.
- **Stage 2**: (1 Day Minimum) Add simple movement activities (EG. running drills) for 30 minutes or less at intensity no greater than 80% of maximum heart rate
- **Stage 3**: (1 Day Minimum) Progress to more complex training for 45 minutes or less at intensity no greater than 80% maximum heart rate. May add light resistance training.
- **Stage 4**: (2 Days Minimum) Normal Training Activity for 60 minutes or less at intensity no greater than 80% maximum heart rate
- **Stage 5**: Return to Full Activity/PE

****Cleared for Full Participation by School Personnel (Minimum 7 days spent on RTP) Yes____ No____**

***CLEARANCE NOTE FROM APPROVED MEDICAL PERSONNEL REQUIRED FOR FULL RTP/PE PARTICIPATION***