RETURN-TO-PLAY FORM

Covid-19 Infection Medical Clearance Releasing the Student-Athlete to Resume Full Participation in Athletics

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This form must be signed by one of the following examining Licensed Health Care Providers (LHCP) before the student-athlete is allowed to resume full participation in athletics: Licensed Physician (MD/DO), Licensed Physician Assistant (PA), Licensed Nurse Practitioner (NP). This form must also be signed by the student-athlete's parent/legal custodian confirming the student is free from symptoms and giving permission for their child to resume full participation in athletics.

Name of Student-Athlete: ____ Date of Birth: ____________________
Participating Sport: _____________________________________
Date Covid-19 Infection Diagnosed: _______________________
Location/Facility Test was Completed: ____
If symptomatic, date symptoms resolved: __________________

Status of Symptoms:

- Student was asymptomatic (no symptoms) or mild symptoms (no fever) lasting less than 3 days.
- Student had moderate symptoms (fever and/or symptoms lasting more than 3 days) but was not hospitalized.
- Student had severe symptoms, was hospitalized, and/or had abnormal cardiac testing results.

As the examining LHCP, I confirm that I have examined the student and attest that the above-named student-athlete is now reporting to be completely free of all signs and symptoms of Covid-19.

The student:

- Is cleared to return to participation in athletics and all other activity without restrictions
- Has been Referred to Cardiologist or Primary Care Sports Medicine Physician for further cardiac evaluation or other medical evaluation

____ ______________________

Signature of (check one): ☐ Licensed Physician ☐ Licensed PA ☐ Licensed NP Date

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Name (Printed) *Office Address* *Phone Number*

Parent/Legal Guardian Permission for Their Child to Resume Full Participation in Athletics

By my signature below, I give permission for my child to resume full participation in athletics and any other school activities after having tested positive for the Covid-19 infection. I confirm that my child has been examined by the health-care provider completing this form and that I will notify the school immediately if my child develops new or a return of Covid-like or cardio-pulmonary symptoms. I confirm that should such symptoms occur, my child will not participate in athletics until such symptoms abate and will, if necessary, consult with a medical practitioner.

____ ____________________

Signature of Parent / Legal Guardian *Date*

____ ____________________

Please print and name relationship to student-athlete *Date*

PLEASE RETURN COMPLETED FORM TO THE ATHLETIC TRAINER OR SCHOOL NURSE:

SP: crobinson@stpaulsmd.org, kamajor@stpaulsmd.org or nurses@stpaulsmd.org **SPSG: smolinaro@stpaulsmd.org or jstallings@stpaulsmd.org**

Resource: *Journal of the American Medical Association of Cardiology*

Figure Below: *Suggested algorithm for approaching pediatric patients with a history of Covid infection who want to return to sports participation and physical activity*