



**RETURN TO PHYSICAL ACTIVITY AFTER COVID-19  
Medical Clearance Form**

This form must be signed by one of the following Licensed Health Care Providers (LHCP) before the student is allowed to resume participation in physical activity: **Licensed Physician (MD/DO), Licensed Physician Assistant (PA), or Licensed Nurse Practitioner (NP)**. This form must be signed by the student's parent/guardian giving their consent before their child resumes participation in athletics and/or physical education class.

Name of Student: \_\_\_\_\_ DOB: \_\_\_\_\_

Participating Sport/Activity: \_\_\_\_\_

Date of COVID-19 Infection Diagnosed: \_\_\_\_\_

If symptomatic, date symptoms resolved: \_\_\_\_\_

**Student's COVID Case:**

- Asymptomatic (no symptoms) or mild symptoms <= 4 days and NO FEVER
- Moderate symptoms (fever and symptoms lasting > 4 days, non-ICU hospitalization and no evidence of MIS-C)
- Severe symptoms (ICU hospitalization and/or intubation, evidence of MIS-C and/or abnormal cardiac testing)
- Athletic activity causes cardio-pulmonary symptoms, such as shortness of breath, chest pain, palpitations, or excessive fatigue

**As the examining LHCP, I attest that the above-named student has completed the quarantine period and all COVID-19 symptoms have resolved for the appropriate length of time. The student is either cleared for resumption of physical activity or recommended for cardiology referral.**

- Cleared for full return to athletics and/or physical education class
- Cleared for return to physical activity after the completion of a graduated return to play due to the severity of symptoms and/or hospitalization associated with the student's positive COVID-19 diagnosis.
- Refer to cardiologist or primary care sports medicine for further cardiac evaluation

\_\_\_\_\_  
Signature of Physician, Licensed Physician's Assistant or Licensed Nurse Practitioner (Please circle)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Address

\_\_\_\_\_  
Phone Number

**Parent/Guardian Consent for Their Child to Resume Full Participation in Athletics and/or Physical Education**

I am aware that Garrison Forest School requests the consent of a child's parent or guardian prior to them resuming full participation in physical activity after having been diagnosed for a COVID-19 infection. By signing below, I hereby give my consent for my child to resume full participation in athletics and/or physical education class. *I understand that if my child develops a new or a return of COVID-like or cardio-pulmonary symptoms (shortness of breath, chest pain, palpitations, or excessive fatigue) when returning to physical activity, my child should stop participation and consult with the LHCP.*

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name and Relationship to Student