Brentwood Union Free School District
Athletic Clearance after COVID-19 Infection

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 be signed by the student-athlete's parent/legal custodian giving their consent before their child resumes full participation in athletics.

Name of Student Athlete-_____ DOB- _____
Participating Sport(s):_____

Date COVID-19 Infection Diagnosed: _____

If symptomatic, date symptoms resolved: _____

COVID Case-

☐ Asymptomatic (no symptoms) or mild symptoms (fever, myalgia, chills, and lethargy < 4 days)

☐ Moderate symptoms (fever, myalgia, chills or lethargy lasting >=4 days or hospitalized but not in ICU)
☐ Severe symptoms (hospitalized in ICU and/or MIS-C)

I attest that the above-named student-athlete is now reporting to be completely free of all signs and symptoms of COVID-19, at least 10 days from positive test, and afebrile for 24 hours and is either cleared for resumption of activity or recommended for cardiology referral.

☐ Cleared for return to athletics.

☐ Not Cleared: Cardiology consultation before clearance.

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

Please Print Name _____ Date- _____

STAMP/PRINT Office Address Phone Number –

_____

****

Parent/Guardian Consent for Their Child to Resume Full Participation in Athletics -

I am aware that Brentwood Union Free School District requests the consent of a child's parent or legal custodian prior to them resuming full participation in athletics after having been diagnosed with a COVID-19 infection. I am giving my consent for my child to resume full participation in athletics. By signing below, I hereby give my consent for my child to resume full participation in athletics. I understand if my child develops symptoms such as chest pain, shortness of breath, excessive fatigue, feeling lightheaded, or palpitations (racing heart), that my athlete should stop exercising immediately and consultation with LHCP will be necessary.

Signature of Parent/ Guardian-_____ Date- _____

04/2021sa