Onteora Central School District
COVID Activity Clearance Form
POST-COVID-19 Diagnosis

Student Name: _____

DOB:_____ **Sport:** _____

Health Care Provider Name (Please Print):_____

Date of onset of COVID symptoms: _____

Date of COVID positive test: _____

Date of resolution of COVID symptoms: _____

Symptoms longer than 4 days? _____No _____Yes

Hospitalization due to COVID symptoms? _____No _____Yes

History of Cardiac abnormalities or followed by cardiology _____No _____Yes

Recent Symptoms:

Chest pain at rest or with exertion? _____No _____Yes

Shortness of breath with minimal activity? _____No _____Yes

Excessive fatigue with exertion? _____No _____Yes

Abnormal heartbeat or palpitations? _____No _____Yes

Syncope or near-syncope? _____No _____Yes

Exam

Normal exam? _____No _____Yes

Normal Cardiovascular exam? _____No _____Yes

EKG completed? _____No _____Yes

Referral to Cardiology _____No _____Yes

Clearance

Cleared for Full-Activity/ Phys.Ed/ Sports _____No _____Yes

Gradual return Progression Protocol required _____No _____Yes

_____ _____ _____

Healthcare Provider Signature Printed Name or Stamp Date

PLEASE RETURN COMPLETED FORM TO SCHOOL NURSE AS SOON AS POSSIBLE

Medical Director reviewed: _____
8-21-21