RETURN TO PLAY FORM: COVID-19 INFECTION MEDICAL CLEARANCE
RELEASING THE STUDENT-ATHLETE TO RESUME FULL PARTICIPATION IN ATHLETICS

- **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).**
- **Licensed Health Care Professionals: Please also complete the second page of this form. It is titled the COVID 19 Gradual return to play protocol. Please circle and initial which stage the student athlete should begin the COVID RTP based upon your examination/assessment. Also sign and date the form below**
- **If no staging is required, please circle and initial stage 6. Please sign and date the form. Thank you.**

Name of Student-Athlete: _____ DOB: _____

Date COVID-19 Infection Diagnosed: _____ Date COVID-19 Infection Resolved: _____

This is to certify that the above-named student-athlete has been diagnosed and treated for COVID-19 infection.

As the examining LHCP, I attest that the above-named student-athlete is now reporting to be completely free of all signs and symptoms of COVID-19 and has had negative results on all the appropriate cardiopulmonary diagnostic studies. By signing below therefore, I give the above-named student- athlete consent to resume full participation in athletics.

_____

Signature of Licensed Health Care Provider Date

_____

Please Print Name (May use stamp)

_____ _____

Please Print Office Address Phone Number

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

Parent/Legal Custodian Consent for Their Child to Resume Full Participation in Athletics

I am aware that the Wesleyan Christian Academy Athletics **REQUIRES** the consent of a child's parent or legal custodian prior to them resuming full participation in athletics after having been diagnosed and treated for a COVID-19 infection. I acknowledge that the Licensed Health Care Provider above has overseen the treatment of my child's COVID-19 infection care and has given their 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.

_____

Signature of Parent/Legal Custodian Date

_____

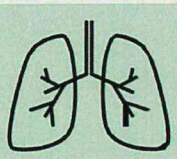
Please Print Name and Relationship to Student-Athlete

N.C.I.S.A.A. # COVID-19 Gradual Return to play protocol N.C.I.S.A.A

This guidance is aimed at athletes with mild to moderate symptoms of COVID-19. Athletes should follow their state, local government and pediatrician's guidelines for management of symptoms including isolation and testing processes.

It is strongly recommended that athletes who have more complicated infections (ie severe symptoms, underlying health conditions, family history, hospital intervention/support) have medical assessments done by their pediatrician before beginning the GRTP under medical supervision.

Blood Testing for markers of inflammation. Physician could consider renal & hematology monitoring.



Respiratory & Cardiovascular function assessments (Spirometry, Treadmill test)

Cardiac Monitoring (ECG, ECHO, ETT, Cardiac MRI)

The athlete must meet the following criteria to begin Stage 2:

DAYS FROM (+) TEST DATE

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HOURS SYMPTOM FREE

\+

HOURS OFF ANY FEVER REDUCING MEDICATION

To be completed by physician only:

The athlete listed below meets all of the listed requirements.

YES **NO**

INITIAL: _____

Athlete Name: _____ DOB: _____

Date of Symptom Onset: _____ Date of (+) COVID Test: _____

	STAGE 1 Quarantine	STAGE 2	STAGE 3	STAGE 4	STAGE 5	STAGE 6
EXERCISE ALLOWED	WALKING & ACTIVITIES OF DAILY LIVING	WALKING JOGGING STATIONARY BIKE NO RES. TRAINING	SIMPLE MOVEMENT ACTIVITIES EG. RUNNING DRILLS	NORMAL TRAINING ACTIVITIES	NORMAL TRAINING PROGRESSIONS	RETURN TO NORMAL TRAINING & PARTICIPATION.
% OF HR MAX TARGET HR		<70%	<80%	<80%	<80%	NAME & CREDENTIALS OF RTP SUPERVISING MEDICAL PROFESSIONAL:
DURATION	10 DAY MINIMUM	2 DAY MINIMUM <15 MIN	1 DAY MINIMUM <30 MIN	1 DAY MINIMUM <45 MIN	2 DAY MINIMUM <60 MIN	
MONITOR	SUBJECTIVE SX RESTING HR	SUBJECTIVE SX RESTING HR, RPE	SUBJECTIVE SX RESTING HR, RPE	SUBJECTIVE SX RESTING HR, RPE	SUBJECTIVE SX RESTING HR, RPE, I-PRRS	

By signing below the supervising physician agrees that the student-athlete may begin a gradual return to full athletic play & participation.

Physician Name: _____

Physician Signature: _____ Date: _____