

COVID-19 Return to Sport

An athlete who has recovered from COVID-19 must be cleared by an approved healthcare provider before returning to exercise or sport activity. When symptoms have resolved, please take this form to the athlete's PCP for physical exam, consideration for further testing, and clearance for return to sport.

Athlete's Name _____ DOB: _____ Date of Positive Test: _____
Date of Onset of Symptoms: _____ Date of Resolution of Symptoms: _____

Date of Physical Exam: _____
Healthcare Provider fills out this section

Screening questions: (All answers below must be no to RTP)

Chest pain/tightness with exercise: _____ YES _____ NO
Unexplained syncope/near syncope: _____ YES _____ NO
Unexplained/excessive dyspnea/fatigue with exertion: _____ YES _____ NO
New palpitations: _____ YES _____ NO
Heart murmur on exam: _____ YES _____ NO

Athlete was completely asymptomatic entire duration of illness:	Athlete experienced mild symptoms: < 4 days of fever and < 1 week myalgia, chills, lethargy	Athlete experienced moderate symptoms: 4+ days of fever or 1+ week myalgia, chills, lethargy; non-ICU hospital stay and no evidence of MIS-C	Athlete experienced severe symptoms: ICU or MIS-C
- At least 10 days after <i>positive test</i> - In person physical and cardiac examination	- At least 10 days after <i>onset of symptoms</i> - At least 24 hours without symptoms or medication - In person physical and cardiac examination	- At least 10 days after positive test AND 10 days symptom free without medication - In person physical and cardiac examination	- Restricted from sports or strenuous exercise for 3-6 months - Referral to Cardiology recommended for clearance

Please provide date and results of EKG if performed:

_____ Athlete IS **cleared** to start the return to activity progression.
_____ Athlete is **NOT cleared** and is being referred for cardiology for further work up.

Evaluating Medical Office Information (Please Print or Stamp)

Evaluator's Name: _____ Office Phone: _____
Evaluator's Address: _____
Evaluator's Signature: _____ License Number: _____

Please take this clearance sheet back to your school's Athletic Trainer. They will coordinate the graduated return to play progression with you as outlined on following page.

COVID-19 Return to Sport

COVID-19 Return to Play Progression

Athlete's Name _____ **DOB:** _____ **Date of Positive Test:** _____
Date of Onset of Symptoms: _____ **Date of Resolution of Symptoms:** _____

Stage	Number of Days minimum	Requirement	Exercise	Heart Rate	Date Completed and ATC initials
One	2	< or = 15 minutes	Light Activity: walk, jog, bike	70% max	
Two	1	< or = 30 minutes	Simple Movement Activity: Bodyweight exercises/running drills	80% max	
Three	1	< or = 45 minutes	Complex training (Sport specific drills) and light weight training	80% max	
Four	2	< or = 60 minutes	Normal activity/practices	80% max	
Five	n/a	Full Return	Return to full activity/games	n/a	

This athlete has successfully completed their 7 day graduated return to play progression. They are cleared to resume normal sports participation.

School ATC Name _____
School ATC Signature _____ **Date** _____