

Assessment/Release for Return to Play Following COVID-19 Infection

Every student-athlete who has tested positive for COVID-19 must be cleared by an outside healthcare provider.

Patient: _____ School: _____

DOB: _____ Sport: _____

Provider/Practice: _____

Date of onset of COVID-19 symptoms: _____

Date of resolution of COVID-19 Symptoms: _____

Date of COVID-19 Positive test result: _____

Systemic symptoms for 3 days or more at time of illness (fever, myalgia, chills, profound lethargy)?: N Y

Hospitalization due to COVID-19 symptoms?: N Y

History of abnormalities previously followed by cardiology?: N Y

Symptoms following COVID-19 infection:

Chest pain with exertion or exercise?: N Y

Shortness of breath with minimal activity?: N Y

Excessive fatigue with activity?: N Y

New abnormal heartbeat or palpitations?: N Y

Unexplained fainting or near fainting?: N Y

Provider Assessment:

Date of exam: _____

Temp: _____ Pulse: _____ BP: _____ RR: _____ Oximetry (if indicated): _____

Normal cardiovascular exam?: Y N

EKG performed Normal Abnormal (Cardiology follow up needed)

Cardiology referral indicated?: N Y

Athlete was not hospitalized due to COVID-19 infection

Criteria to return (Please check below as applies)

- 10 days have passed since onset of symptoms
- No symptoms for 24 hours: no fever >100.4F without antipyretics, no cough or shortness of breath

- Athlete **HAS** satisfied the above criteria and **IS** cleared to return to activity fully, without the return to play progression
- Athlete **HAS** satisfied the above criteria and **IS** cleared to return to activity with return to play progression
- Athlete **HAS NOT** satisfied the above criteria **IS NOT** cleared to return to activity

MEDICAL OFFICE INFORMATION (PLEASE PRINT OR STAMP):

Evaluator's Name: _____ Evaluator's Address/Phone: _____

Evaluator's Signature: _____