Hyde Park Central School District Athletic Department
COVID-19 Return to Athletics - Health Care Provider Clearance Form

Student's Name: _____ DOB: _____

Sports:_____ Date of evaluation:_____

Primary Care Physician:_____

Criteria to begin athletics: (to be completed by Health Care Provider)

Date of onset of Covid symptoms: _____

Date of Positive Covid Test: _____

Date of Resolution of Covid symptoms:_____

Symptoms longer than 4 Days? YES NO

Hospitalization due to Covid symptoms? YES NO

H/O cardiac abnormalities followed by cardiology? YES NO

Recent Symptoms

Chest Pain at Rest or with exertion? (not musculoskeletal or costochondritis)? YES NO

Shortness of breath with minimal activity? (unrelated to respiratory symptoms) ? YES NO

Excessive fatigue with exertion? YES NO

Abnormal heartbeat or palpitations? YES NO

Syncope or near-syncope? YES NO

Cardiology referral indicated? YES NO

Normal Cardiovascular exam? YES NO

Cleared for Gradual Return to Sports? YES NO

MD Signature:_____

MD Printed Name: _____

Date: _____