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 ☐

Normal cardiovascular exam? YES ☐ NO ☐

Cardiology referral indicated? YES ☐ NO ☐

Cleared for Gradual Return to Sports? YES ☐ NO ☐

MD Signature:_____

MD Printed Name: _____

Date: _____