Assessment/Release for Return to Play Following COVID Infection

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

Patient: _____ School: _____

DOB: _____ Sport: _____

Provider/Practice: _____

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Date of onset of COVID symptoms: _____
Date of resolution of COVID Symptoms: _____
Date of COVID Positive test result: _____

Systemic symptoms for 4days or more at time of illness (fever, myalgia, chills, profound lethargy)?:	N☐	Y☐
Hospitalization due to COVID 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 72 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, <u>without</u> the return to play progression
☐ Athlete **HAS** satisfied the above criteria and **IS** cleared to return to activity *<u>with</u>* 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: _____ _____