



Return To Play Clearance Form COVID-19 Infection Medical Clearance

We recommend the use of this form by member schools as it relates to students who have tested positive for Covid-19. This form must be signed by one of the following examining Licensed Health Care Providers (LHCP) before the student-athlete is allowed to resume full participation in athletics: Licensed Physician (MD/DO), Licensed Physician Assistant (PA), Licensed Nurse Practitioner (NP). This form must be signed by the student-athlete's parent/legal custodian giving their consent before their child resumes full participation in athletics.

Name of Student-Athlete: _____ DOB: _____

Participating Sport(s): _____

Date COVID-19 Infection Diagnosed: _____

If symptomatic, date symptoms resolved: _____

COVID Case:

- Asymptomatic (no symptoms) or mild symptoms (fever, myalgia, chills, and lethargy < 4 days)
- Moderate symptoms (fever, myalgia, chills or lethargy lasting >=4 days or hospitalized but not in ICU)
- Severe symptoms (hospitalized in ICU and/or MIS-C)

Some students, particularly those with moderate to severe illness, may require a graduated return-to-play (RTP) protocol once the student has been cleared by a LHCP (cardiologist for moderate to severe COVID-19 symptoms). The American Academy of Pediatrics COVID-19 Interim Guidance: Return to Sport provides a recommendation for RTP (page 2) if necessary.

As the examining LHCP, I attest that the above-named student-athlete is now reporting to be completely free of all signs and symptoms of COVID-19, at least 5 days from positive test, and afebrile for 24 hours and is either cleared for resumption of activity or recommended for cardiology referral.

- Cleared for return to athletics.
- Cleared for return to athletics after completion of a graduated return to play due to the severity of symptoms and/or hospitalization associated with the student's positive COVID-19 diagnosis.
- Not Cleared: Cardiology consultation before clearance.

Signature of Licensed Physician, Licensed Physician Assistant, Licensed Nurse Practitioner (Please Circle) Date

Please Print Name

Please Print Office Address Phone Number

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Parent/Legal Custodian Consent for Their Child to Resume Full Participation in Athletics

I am aware that _____ (school name) requests the consent of a child's parent or legal custodian prior to them resuming full participation in athletics after having been diagnosed with a COVID-19 infection. I am giving my consent for my child to resume full participation in athletics. By signing below, I hereby give my consent for my child to resume full participation in athletics. I understand if my child develops symptoms such as chest pain, shortness of breath, excessive fatigue, feeling lightheaded, or palpitations (racing heart), that my athlete should stop exercising immediately and consultation with LHCP will be necessary.

Signature of Parent/Legal Custodian Date

Please Print Name and Relationship to Student-Athlete

PLEASE RETURN COMPLETED FORM TO YOUR SCHOOL NURSE