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 4 days or more at time of illness (fever, myalgia, chills, profound lethargy)?: Hospitalization due to COVID symptoms?:  History of abnormalities previously followed by cardiology?: | N□ N□ N□ | Y□ Y□ 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, 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: \_