COVID-19 Return to Play Form

Any athlete who has tested positive for Covid-19 or an athlete that has had close contact with an individual, who is positive Covid, and then the exposed athlete develops symptoms but is not tested, MUST be cleared for progression back to activity by a qualified, licensed medical provider. (MD/DO/APRN/PA)

Name of athlete:_____DOB:_____

Date of positive test:_____Date symptoms started:_____Date of last fever (≥100.4F)_____

THIS RETURN TO PLAY IS BASED ON TODAY'S EVALUATION Date of Evaluation: _____

Criteria to return (Please check below as applies)

❑10 days have passed since symptoms first appeared and symptoms have resolved (No fever (≥100.4F) for 24 hours without fever reducing medication, improvement of symptoms (cough, shortness of breath) OR was asymptomatic for 10 days following positive test

❑Athlete was not hospitalized due to COVID-19 infection.

❑Cardiac screen negative for myocarditis/myocardial ischemia (All answers below must be no)

Chest pain/tightness with exercise	YES ❑NO ❑
Unexplained Syncope/near syncope	YES ❑NO ❑
Unexplained/excessive dyspnea/fatigue w/exertion	YES ❑NO ❑
New palpitations	YES ❑NO ❑
Heart murmur on exam	YES ❑NO ❑

NOTE: If any cardiac screening question is positive or if athlete was hospitalized, consider further workup as indicated. May include CXR, Spirometry, PFTs, Chest CT, Cardiology Consult

❑Athlete HAS satisfied the above criteria and IS cleared to start the return to activity progression.

❑Athlete HAS NOT satisfied the above criteria and IS NOT cleared to return to activity

Medical Office Information (Please Print/Stamp):

Evaluator's Name: _____

Office Phone: _____Fax Number:_____

Evaluator's Address: _____

Evaluator's Signature: _____

1/21/2021