RETURN-TO-ACTIVITY FORM

Covid-19 Infection Medical Clearance Releasing the Student to Resume Full Participation in Sports and Physical Activity

This form must be signed by the student-athlete's parent/legal custodian confirming the student is free from symptoms and giving permission for their child to resume full participation in physical activity.

Name of Student: _____ Date of Birth: _____

Participating Sport: _____ Date Covid-19 Infection Diagnosed: _____

Location/Facility Test was Completed: _____

If symptomatic, date symptoms resolved: _____

Status of Symptoms:

- ☐ 1. Student was asymptomatic (no symptoms) or mild symptoms (no fever) lasting less than 4 days.
- ☐ 2. Student had moderate symptoms (fever and/or symptoms lasting more than 4 days) but was not hospitalized.
- ☐ 3. Student had severe symptoms, was hospitalized, and/or had abnormal cardiac testing results.

If you checked box 2 or 3, this form must be signed by one of the following examining Licensed Health Care Providers (LHCP) before the student is allowed to resume full participation in athletics: Licensed Physician (MD/DO), Licensed Physician Assistant (PA), Licensed Nurse Practitioner (NP). As the examining LHCP, I confirm that I have examined the student and attest that the above-named student-athlete is now reporting to be completely free of all signs and symptoms of Covid-19.

The student:

- ☐ Is cleared to return to participation in athletics and all other activity without restrictions
- ☐ Has been Referred to Cardiologist or Primary Care Sports Medicine Physician for further cardiac evaluation or other medical evaluation

_____ _____

Signature of (check one): ☐ Licensed Physician ☐ Licensed PA ☐ Licensed NP Date

_____

Name (Printed) *Office Address* *Phone Number*

Parent/Legal Guardian Permission for Their Child to Resume Full Participation in Athletics

By my signature below, I give permission for my child to resume full participation in athletics and any other school activities after having tested positive for the Covid-19 infection. I confirm that I will notify the school immediately if my child develops new or a return of Covid-like or cardio-pulmonary symptoms. I confirm that should such symptoms occur, my child will not participate in athletics until such symptoms abate and will, if necessary, consult with a medical practitioner.

_____ _____

Signature of Parent / Legal Guardian *Date*

_____ _____

Please print and name relationship to student-athlete *Date*

PLEASE RETURN COMPLETED FORM TO THE ATHLETIC TRAINER OR SCHOOL NURSE:
SP: crobinson@stpaulsmd.org, kealey@stpaulsmd.org or nurses@stpaulsmd.org
SPSG: smolinaro@stpaulsmd.org or jstallings@stpaulsmd.org