



## RETURN TO SPORTS AFTER COVID-19 Medical Clearance Form

This form must be signed by one of the following 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), or Licensed Nurse Practitioner (NP)**. This form must be signed by the student-athlete's parent/guardian giving their consent before their child resumes full participation in athletics.

Name of Student-Athlete: \_\_\_\_\_ DOB: \_\_\_\_\_

Participating Sport: \_\_\_\_\_

Date of COVID-19 Infection Diagnosed: \_\_\_\_\_

If symptomatic, date symptoms resolved: \_\_\_\_\_

### Student-Athlete's COVID Case:

- Asymptomatic (no symptoms) or mild symptoms  $\leq$  3 days and NO FEVER
- Moderate symptoms (fever and/or symptoms lasting  $>$  3 days but not hospitalized)
- Severe symptoms, hospitalized and/or abnormal cardiac testing
- Athletic activity causes cardio-pulmonary symptoms, such as shortness of breath, chest pain, palpitations, or excessive fatigue

**As the examining LHCP, I attest that the above-named student-athlete has completed the quarantine period and all COVID-19 symptoms have resolved for 14 days. The student-athlete is either released for full activity or recommended for cardiology referral. See possible recommendations on the second page.**

- Cleared for full return to athletics
- Refer to cardiologist or primary care sports medicine for further cardiac evaluation

\_\_\_\_\_  
Signature of Licensed Physician, Licensed Physician's Assistant or Licensed Nurse Practitioner (Please circle)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Address

\_\_\_\_\_  
Phone Number

### **Parent/Guardian Consent for Their Child to Resume Full Participation in Athletics**

I am aware that Garrison Forest School requests the consent of a child's parent or guardian prior to them resuming full participation in athletics after having been diagnosed for a COVID-19 infection. By signing below, I hereby give my consent for my child to resume full participation in athletics. *I understand that if my child develops new or a return of COVID-like or cardio-pulmonary symptoms (shortness of breath, chest pain, palpitations, or excessive fatigue) when returning to athletics, my child should stop participation in sports and consult with the LHCP.*

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name and Relationship to Student-Athlete

Figure below: suggested algorithm for approaching pediatric patients with a history of a COVID infection who want to return to sports participation and physical activity.

## Return to Play After COVID-19 Infection in Pediatric Patients

