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: _____

How many times have you tested positive for COVID -19: _____

_____

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

Physicians Comments: _____

_____

__ 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: _____ _____