**The following is a sample form that may be used as a template in the development of an individual school district approved form to document and return a student-athlete to physical activity after a COVID-19 positive test.**

**Any use of this form should be approved by individual school district doctors and legal counsel. The CIAC is not a medical provider nor legal counsel. This form is provided as a courtesy and is intended to be a template that member schools may adapt and use in consultation with their healthcare staff and legal counsel to develop their district approved form.**

**COVID-19 Return to Physical Activity Release From**

**Student must fulfill [School District Name] Public Schools isolation requirements**

\*The information below must be completed by the student’s licensed medical professional pursuant to

chapter 370 (MD/DO), a physician assistant licensed pursuant to chapter 370 (PA-C) or an advanced

practice registered nurse licensed pursuant to chapter 378 (APRN)\*

\*\*Once completed by Physician (MD/DO), APRN or PA-C, and the student is cleared to return to

physical activity, they must obtain final return to sport clearance with the athletic training staff before

they can return to practice or competition\*\*

Student’s First and Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of COVID-19 positive test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of COVID-19 symptom resolution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Severity (check one): [ ]  Asymptomatic [ ]  Mild [ ]  Moderate [ ] Severe

Known significant heart disease (check one): [ ]  Yes [ ]  No

Following resolution of acute COVID-19 infection, has the patient had:

 Chest pain/discomfort/tightness/pressure: [ ]  Yes [ ]  No

 Unexplained syncope or near syncope: [ ]  Yes [ ]  No

Unexplained shortness of breath or fatigue: [ ]  Yes [ ]  No

Palpitations: [ ]  Yes [ ]  No

On exam, the patient had:

 Abnormal cardiac findings (murmur, gallop, etc.) [ ]  Yes [ ]  No

 Hepatomegaly: [ ]  Yes [ ]  No

 Abnormal pulmonary findings: [ ]  Yes [ ]  No

 Swelling/edema: [ ]  Yes [ ]  No

Do you have any other concerns about the patient returning to physical activity? [ ]  Yes [ ]  No

If the severity is asymptomatic or mild and all of the above are “No,” the patient may be cleared to return to play without a Pediatric Cardiology referral or specific cardiac testing.

\*This form does not take place of routine pre-participation screening, which includes additional questions

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**Medical Authorization Form:**

**Participation Clearance Following a COVID-19 Infection**

**Glastonbury High School Athletics**

**Health Care Provider Authorization**

Based upon the assessment completed on \_\_\_/\_\_\_/\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

 (student’s first & last name)

\_\_\_/\_\_\_/\_\_\_ is medically cleared to return to physical activity as determined below:

(date of birth)

***Physician must check one (1) box below, otherwise, the student athlete will be required to complete all five (5) stages of the AAP Gradual Return-to-Play (RTP) Plan as identified in the CIAC Winter Sports Plan:***

 □ Athlete is cleared to return to all athletic activities, including competition

* *this confirms the assessment of the student incorporated AAP RTP protocol*
* *student-athlete must complete at least* ***one*** *practice session before eligible for game play; under the direction of the athletic trainer in consultation with coaching staff*

 □ Athlete is cleared to enter AAP RTP protocol, starting at:

 □ Stage 1

 □ Stage 2

 □ Stage 3

 □ Stage 4 – Day 1

 □ Stage 4 – Day 2

 □ Athlete is cleared to return to physical activity but must complete Stages 1-5 of the AAP RTP plan

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ (health care provider name, printed) (health care provider signature) (date)

**Parent/Legal Guardian Authorization**

I attest that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has been evaluated by an

 (student’s first & last name)

authorized medical provider and give my consent for his/her participation in a phased approach to in their

return to the sports program at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ following the guidelines of the CIAC

 (name of school)

protocol for a gradual return to play.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

(parent/guardian name, printed) (parent/guardian signature) (date)