SACRED HEART CATHEDRAL
PREPARATORY

COVID-19 Physician Form

Name of Student: _____ Date:_____

DATE OF EXAM: _____ DATE OF POSITIVE TEST: _____

Athlete must meet criteria in order to return to FULL activity/sport. **(Health Care Provider: Please check all that apply)**

- ☐ 5 days have passed since asymptomatic positive test & proof of negative rapid test **OR** 5 days from onset of symptoms & proof of negative rapid test **OR** 10 days have passed since asymptomatic positive test **OR** 10 days from onset of symptoms
- ☐ Symptoms have resolved (No fever greater than 100.4°F for 24 hours without fever reducing medication, and no cough, shortness of breath, etc.)
- ☐ Athlete was not hospitalized

Athletes who have experienced moderate to severe COVID-19 (any of the following):

- Cardiopulmonary symptoms (shortness of breath, chest pain/pressure/tightness, palpitations, fainting),
- Central nervous system (prolonged headache)
- Systemic symptoms (prolonged fever/chills or prolonged fatigue for more than 3 days)
- Hospitalization

...must provide clearance from Health Care Provider AND go through the CIF Gradual Return to Play Protocol (return to activity progression).

Recommended:

- Cardiology consultation (if not done during hospitalization)
- Cardiac testing (e.g., ECG, troponin, echocardiogram)

PHYSICAL ACTIVITY STATUS

____ Student-Athlete has satisfied all criteria and is medically cleared for FULL Participation

____ Student-Athlete has satisfied all criteria and is medically cleared to begin the CIF Gradual Return to Play Protocol

____ Student-Athlete IS NOT medically cleared to return to athletics or begin the CIF Gradual Return to Play Protocol.

Comments: _____

_____

Physician's Signature (MD or DO): _____Date: _____

Physician's Office Stamp/Contact Information