



**SACRED HEART CATHEDRAL**  
PREPARATORY

COVID-19 Physician Form

Name of Student: \_\_\_\_\_ Date: \_\_\_\_\_

**DATE OF EXAM:** \_\_\_\_\_ **DATE OF POSITIVE TEST:** \_\_\_\_\_

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

- 10 days have passed since asymptomatic positive test **OR** 10 days from onset of symptoms with at least 7 days with no symptoms (exception is loss of taste or smell)
- Symptoms have resolved (No fever greater than 100.4°F for 24 hours without fever reducing medication, and improvement of symptoms such as cough, shortness of breath, etc.)
- Normal lung exam
- Athlete was not hospitalized (if hospitalized, follow myocarditis return to play guidelines)
- Cardiac screen negative for myocarditis/myocardial ischemia

Chest pain/tightness with exercise YES \_\_\_ NO \_\_\_

Unexplained syncope/near syncope YES \_\_\_ NO \_\_\_

Unexplained or excessive dyspnea or fatigue with exertion YES \_\_\_ NO \_\_\_

New palpitations YES \_\_\_ NO \_\_\_

Heart murmur on exam YES \_\_\_ NO \_\_\_

- Normal ECG (For moderate symptoms (prolonged fever and bed rest, no hospitalization, no abnormal cardiac testing) athlete must complete an ECG to rule out prior to clearance)

**PHYSICAL ACTIVITY STATUS**

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

\_\_\_ Student-Athlete has NOT satisfied all criteria and IS NOT medically cleared to begin return to activity progression

Comments: \_\_\_\_\_  
\_\_\_\_\_

Physician's Signature (MD or DO): \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Office Stamp/Contact Information