

COVID-19 Return to Play Medical Authorization

This information below must be filled out by the student's medical provider

Patient's Name: _____ Date of Birth: _____

Date of positive COVID-19 test: ___/___/___ Date of COVID-19 symptom resolution: ___/___/___

Severity: Asymptomatic Mild Moderate Severe

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

Known significant heart disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
---------------------------------	------------------------------	-----------------------------

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

Chest pain/discomfort/tightness/pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Unexplained syncope or near syncope	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Unexplained shortness of breath or fatigue	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Palpitations	Yes <input type="checkbox"/>	No <input type="checkbox"/>

On exam, has the patient had:

Abnormal cardiac findings (murmur, gallop, etc.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatomegaly	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Abnormal pulmonary findings	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Swelling/edema	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Do you have any other concerns about the patient returning to play? Yes No

If yes, please state concerns: _____

Medical Provider Authorization

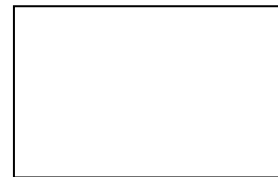
Based upon today's physical examination, the above patient is medically cleared to participate in the competitive sports program at Newington High School within the guidelines of the CIAC protocol for gradual return to play.

Provider's Name: _____

Telephone: _____ Fax: _____

Address: _____

Provider's Signature: _____ Date: _____



Use for Provider's Stamp

Parent/Legal Guardian

I hereby attest that _____ has been evaluated physically by an authorized medical provider and give my consent for his/her participation in the competitive sport's program at Newington High school within the guidelines of the CIAC protocol for a gradual return to play.

(Parent/Guardian name printed)

(Parent/Guardian signature)

___/___/___
(Date)