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 ☐	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, has 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 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)