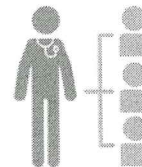


Post COVID-19 Student "Return to Activity/Play" Clearance Form

n a s s a u
BOCES
Health and Allied Services

**MEDICAL
DIRECTOR
SERVICE**



If a student has tested positive for COVID-19, he/she must be cleared for progression back to activity by an approved health care provider.
(MD/DO/PAC/ARNP)

Student Name: _____ DOB: _____ Date of Positive Test: _____

The "Return to Activity/Play" for the student named above is based on today's evaluation.

Date of Evaluation: _____

Criteria to return (Please check all that apply)

- 10 days have passed since symptoms first appeared and symptoms have resolved.
- No fever $\geq 100.0^{\circ}\text{F}$ for 72 hours without fever reducing medication.
- Improvement of symptoms (cough, shortness of breath) **OR** student has been asymptomatic for 10 days following positive test.
- Student was **not** hospitalized due to COVID-19 infection.
- Cardiac screen negative for myocarditis/myocardial ischemia has been performed.

Chest pain/tightness with exercise..... YES NO

Unexplained Syncope/near syncope..... YES NO

Unexplained/excessive dyspnea/fatigue w/exertion..... YES NO

New palpitations..... YES NO

Heart murmur on exam..... YES NO

NOTE: If any cardiac screening question is positive or if student was hospitalized, consider further workup as indicated.

YES NO The student has satisfied the all the above criteria and is medically cleared to start the return to activity progression. (see reverse for RTP Progression Care Plan)

Name of Medical Office: _____

Office Phone: _____

Evaluator's Name (MD/DO/PAC/ARNP): _____

Evaluator's Signature: _____