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

nassau 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 ≥100.0°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: _____