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)*

Date of Evaluation: _____

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

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

HCP – Please check one of the following:

Yes____ No_____ The student has satisfied all of the above criteria and is medically cleared to return to all activities.

Yes____ No_____ The student is cleared to start the Return to Play protocol after displaying moderate to severe symptoms during COVID illness.

Name of Medical Office: _____

Office Phone: _____

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

Evaluator's Signature: _____