Penn Medicine
Lancaster General Health

COVID-19 Return to Sport

An athlete who has recovered from COVID-19 must be cleared by an approved healthcare provider before returning to exercise or sport activity. When symptoms have resolved, please take this form to the athlete's PCP for physical exam, consideration for further testing, and clearance for return to sport.

Athlete's Name ____________________________ DOB: ______________ Date of Positive Test: ______________

Date of Onset of Symptoms: __________________ Date of Resolution of Symptoms: ____________________

Please mark all symptoms experienced				
Cough:	Shortness of breath:	Fever:	Loss of taste/smell:	Congestion:
Headache:	Muscle Aches:	Sore Throat:	Nausea/diarrhea:	Other:

Date of Physical Exam: ______________________

Healthcare Provider fills out this section

Screening questions: (All answers below must be no to RTP)

Chest pain/tightness with exercise: ____YES ______NO
Unexplained syncope/near syncope: ____YES ______NO
Unexplained/excessive dyspnea/fatigue with exertion: ____YES______NO
New palpitations: ____YES ______NO
Heart murmur on exam: ____YES ______NO

Athlete was completely **asymptomatic** entire duration of illness:	Athlete experienced **mild** symptoms: (<4 days of fever, <1 week myalgia, chills, lethargy)	Athlete experienced **moderate** symptoms: (4+ days of fever, 1+ week myalgia, chills, lethargy, non-ICU hospital stay and no evidence of MIS-C)	Athlete was **hospitalized**: (ICU or MIS-C)
-At least 10 days after *positive test* -In person physical and cardiac examination	-At least 10 days after *positive test* -In person physical and cardiac examination	-Exercise restriction until 10 days *symptom free* -In person physical and cardiac examination -EKG for students ages 12+	-Referral to Cardiology recommended for clearance

Please provide date and results of EKG. If there was no EKG was performed, please provide reason why.

____

______Athlete IS **cleared** to start the return to activity progression.
______Athlete is **NOT cleared** and is being referred for cardiology for further work up.

Evaluating Medical Office Information (Please Print or Stamp)

Evaluator's Name:________________________Office Phone:________________________________

Evaluator's Address:____

Evaluator's Signature:_____________________________License Number:___________________________

Please take this clearance sheet back to your school's Athletic Trainer. They will coordinate the graduated return to play progression with you as outlined on following page.

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COVID-19 Return to Play Progression

Athlete's Name _________________________ DOB: ______________ Date of Positive Test: _________________
Date of Onset of Symptoms: _______________ Date of Resolution of Symptoms: __________________________

Stage	Number of Days minimum	Requirement	Exercise	Heart Rate	Date Completed and ATC initials
One	2	< or = 15 minutes	Light Activity: walk, jog, bike	70% max	
Two	1	< or = 30 minutes	Simple Movement Activity: Bodyweight exercises/running drills	80% max	
Three	1	< or = 45 minutes	Complex training (Sport specific drills) and light weight training	80% max	
Four	2	< or = 60 minutes	Normal activity/practices	80% max	
Five	n/a	Full Return	Return to full activity/games	n/a	

This athlete has successfully completed their 7 day graduated return to play progression. They are now cleared to resume normal gym and recess participation.

School ATC Name __________________________________
School ATC Signature ______________________________ **Date** ________________