Penn Medicine
Lancaster General Health

COVID-19 Return to Sports

If an athlete has tested positive for COVID-19, he/she must be cleared for progression back to activity by an approved healthcare provider. AFTER student-athlete is symptom-free for 14 days, please take this form to their 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 the patient has experienced or currently has	**M=Mild** **S=Severe** **NE=Not experienced**			
Cough:	Shortness of breath:	Fever:	Loss of taste:	Loss of smell:
Headache:	Muscle Aches:	Sore Throat:	Nausea:	Diarrhea:

Healthcare Provider fills out this form

Date of Physical Exam: _____

Criteria to return (Please check below as applies)

_____14 days have passed since onset of symptoms OR has been asymptomatic throughout 14 days of quarantine
_____In person physical and cardiac exam by approved healthcare provider
_____Athletes between the ages 13-18 are required to undergo EKG at least 14 days after symptoms have resolved unless completely asymptomatic.
_____Athlete was not hospitalized due to COVID-19 infection

Cardiac screen negative for myocarditis/myocardial ischemia (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

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

_____

_____Athlete HAS satisfied the above criteria and 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 AT 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	
Four					
Five	n/a	Full Return	Return to full activity	n/a	

This athlete has successfully completed their 7 day graduated return to play progression. They are now cleared to resume normal sport activity.

Athletic Trainer's Name _____
Athletic Trainer's Signature _____ **Date** _____