Post COVID-19 Return to Sports/Activity Clearance Form

Student Name: ____ DOB: ______________

Date of Positive COVID Test/ Symptom: __________________________

Please circle the appropriate response regarding your students recent COVID illness.

Vaccination 1 Date: _____________________ Vaccination 2 Date: _____________________

Booster Date: _________________________ Check here if unvaccinated: __________

Has had a fever > 100.5 in the last 24 hours…………………………………………………YES NO

Was the student hospitalized due to COVID-19 Infection……………………………….YES NO

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

Unexplained lightheadedness or passing out ………………………………………………..YES NO

Shortness of Breath with exertion ……………………………………………………………………YES NO

New palpitations ………………………………………………………………………………...………YES NO

Any yes response will require a note be submitted by your private physician before your child is allowed to return to sports safely. Please print your name and sign below attesting to the above responses.

Parent or Guardian Print and Sign you Name: ____

Date form completed: __________________________