COVID-19 RELEASE FORM

thlete's Name:_____ Student ID:_____

chool:_____ Sport(s):_____

PAST MEDICAL HISTORY

ONLY complete the "PAST MEDICAL HISTORY" portion with a parent/guardian. Answer the following questions truthfully and accurately.

Yes:	No:	Pertinent Covid-19 Past Medical History
		1. Have **YOU** been tested and diagnosed positive for COVID-19 at any time? **If "YES", when was date of diagnosis?:* _____
		If question #1 was answered "YES", also answer question #2
		2. Did you have any symptoms at the time of the positive COVID-19 diagnosis? **If "YES", list symptoms here:* _____ _____ *Start and end date of symptoms here:* _____

IF QUESTIONS #1 AND #2 WERE ANSWERED "NO" PLEASE RETURN THIS FORM TO YOUR ATHLETIC TRAINER.

Parent/Guardian Signature:_____ Student Signature:_____ Date:_____

THE FOLLOWING IS TO BE FILLED OUT BY A HEALTHCARE PROFESSIONAL (MD/DO)
IF PAST MEDICAL HISTORY OF COVID-19 PRESENT (IF ANSWERED "YES" TO QUESTIONS #1 & #2).

INITIAL EVALUATION

The American Academy of Pediatrics (AAP), California Department of Public Health (CDPH), and the California Interscholastic Federation (CIF) recommend student-athletes should not be allowed to compete in athletics after a positive COVID-19 diagnosis unless medically cleared by a physician.

☐ Athlete has previously tested positive for COVID-19 with ***ASYMPTOMATIC OR MILD SYMPTOMS*** (<4 days of fever >100, short duration of myalgia, chills, and lethargy). Athlete ***HAS*** satisfied isolation period and medical clearance and ***IS*** cleared to begin the return to play guidelines under the supervision of the athletic trainer.

☐ Athlete has previously tested positive for COVID-19 with **MODERATE/SEVERE SYMPTOMS** (≥4 days of fever > 100, myalgia, chills, or lethargy, or those who had an ICU hospital stay). Athlete ***HAS NOT*** satisfied medical clearance and ***IS NOT*** cleared to begin return to play protocol until further evaluation and medical clearance is obtained. ***See ADDITIONAL CLEARANCE section***.

Physician's Signature (MD/DO):_____ OFFICE STAMP:

Office Phone: _____ Date of Exam: _____

THE FOLLOWING IS TO BE FILLED OUT BY A HEALTHCARE PROFESSIONAL (MD/DO)
WHEN ADDITIONAL MEDICAL EVAULATIONS ARE DEEMED NECESSARY.

ADDITIONAL CLEARANCE

☐ Athlete has completed any additional medical evaluation(s) and ***IS CLEARED*** to begin the return to play protocol under the supervision of the athletic trainer.

☐ Athlete is not medically eligible, pending further medical evaluation(s): _____
_____

☐ Athlete is not medically eligible for sport(s): _____
_____

Physician Signature(MD/DO): _____ OFFICE STAMP:

Office Phone: _____ Date of Exam: _____