THE JOHN CARROLL SCHOOL

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Return to Physical Activity Following a COVID-19 Infection

Name of Student:_____DOB:_____

Date COVID-19 Infection Diagnosed: _____

Location/Facility Where Test Was Completed: _____

If Symptomatic, Date Symptoms Resolved: _____

Please select which of the following categories best describes student's COVID infection:

___1. **Mild** – no symptoms or mild symptoms <= 3 days and **NO FEVER**.

___2. **Moderate** – symptoms including fever (>100°F) and/or symptoms lasting >3 days but not hospitalized

___3. **Severe** – symptoms including hospitalization and/or abnormal cardiac test result

If the student falls into Category 1 (Mild), the school only requires the signature of the parent/guardian.

Should the student fall into Category 2 or 3 (Moderate or Severe), the school requires a parent/guardian signature PLUS the signature of one of the following Licensed Health Care Providers (LHCP): Licensed Physician (MD/DO), Licensed Physician Assistant (PA), Licensed Nurse Practitioner (NP)

As the LHCP, I attest that the above-named student-athlete is now reporting to be completely free of all signs and symptoms of COVID-19 and is either released for full activity or recommended for cardiology referral.

_____Cleared for return to physical activity.

_____Recommended for consultation with cardiology or primary care sports medicine physician.

LHCP Name:_____ Date: _____

Address:_____ Phone: _____

LHCP Signature: _____

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Parent/Guardian Consent for Their Child to Resume Full Participation in Physical Activity

I am aware that The John Carroll School requires the consent of a child's parent or legal custodian prior to resuming full participation in a school-sponsored physical activity after having been diagnosed for a COVID-19 infection. By signing below, I hereby give my consent for my child to resume full participation in school-sponsored physical activity. I understand that if my child develops new symptoms or a return of COVID-like or cardio-pulmonary symptoms, consultation with a LHCP will be necessary.

Parent/Guardian Signature**:** _____Date: _____

PLEASE RETURN FORM TO SCHOOL ATHLETIC TRAINER (efabriziani@johncarroll.org) OR NURSES (nurses@johncarroll.org).