BLUE HILLS
REGIONAL TECHNICAL SCHOOL
Blue Hills Regional Technical School Athletics 800 Randolph St Canton, MA 02021 781-828-5800 X-2210

If a Student-Athlete has tested positive for Covid-19 he/she must be cleared for progression back to activity by an approved healthcare provider (MD, DO, NP, PA-C).

Athlete's Name:_____DOB:_____

Date of COVID-19 Test:_____

THIS RETURN TO PLAY IS BASED ON TODAY'S EVALUATION

TODAY'S DATE:_____

Criteria to return (Please check below as applies)

- ❑ 5 days have passed since onset of symptoms OR has been asymptomatic throughout 5 days of quarantine
- ❑ Symptoms have resolved (No fever (≥100.4F) for 24 hours without fever reducing medication, improvement of symptoms (cough, shortness of breath)
- ❑ Athlete was not hospitalized due to COVID-19 infection.
- ❑ Cardiac screen negative for myocarditis/myocardial ischemia

(All answers below must be no)

Chest Pain/Tightness with Exercise YES ❑ NO ❑

Unexplained Syncope/Near Syncope/Dizziness YES ❑ NO ❑

Unexplained/Excessive Dyspnea/Fatigue w/Exertion YES ❑ NO ❑

New Palpitations YES ❑ NO ❑

Heart Murmur on exam YES ❑ NO ❑

N**OTE: If any cardiac screening question is positive or if athlete was hospitalized, experiencing symptoms for more than 10 days, or have a pre-existing cardiac condition Cardiology consult could be necessary.**

_____Athlete ***HAS*** satisfied the above criteria and ***IS*** cleared to begin the Return to Sport progression.

_____Athlete ***HAS NOT*** satisfied the above criteria and ***IS NOT*** cleared for activity.

RETURN TO PARTICIPATION AFTER COVID-19

Athlete will be referred back to evaluating provider if symptoms develop, such as chest pain, chest tightness, palpitations or syncope, during progression of back to play.

Stage 1. Light activity

Stage 2. Moderate activity such as running drills, progressing to more complex practice

Stage 3. Full practice at moderate intensity

Stage 4. Return to full activity

MEDICAL OFFICE INFORMATION (Please Print)

Evaluator's Name:_____ Phone:_____

Evaluators Signature:_____

Medical Office Stamp (Required)

Cleared for full participation by Athletic Trainer on DATE:_____

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