

RETURN TO PLAY FORM
Covid-19 Infection Medical Clearance
Releasing the Student Athlete to Resume
Full Participation in Athletics

This form must be signed by one of the following examining Licensed Health Care Providers (LHCP) before the student-athlete is allowed to resume full participation in athletics: Licensed Physicians (MD/DO), Licensed Physician Assistant (PA), Licensed Nurse Practitioner (NP). This form must be signed by the student-athlete's parent/legal guardian giving their consent before their child resumes full participation in athletics.

Name of Student Athlete: _____

DOB: _____ Male / Female

Date Covid-19 Infection Diagnosed: _____

**This is to certify that the above-named athlete has
had a medical assessment for COVID-19 infection**

As the examining LHCP, I have thoroughly assessed the above-named student-athlete (including review of appropriate diagnostic studies, if indicated) and have determined this student-athlete is medically cleared to return to sport. Therefore, by signing below, I give the above-named student-athlete permission to resume full participation in athletics.

Signature of Licensed Physician, Licensed Physician Assistant,
Licensed Nurse Practitioner (Please circle one)

Date

Please Print Name

Please Print Office Address

Office Phone Number

Parent/Legal Guardian Consent for Their Child to Resume Full Participation in Athletics

I acknowledge that my child has been medically cleared to resume full participation in athletics after contracting a COVID-19 infection. By signing below, I hereby give my consent for my child to resume full participation in athletics.

Signature of Parent/Guardian

Date

Please Print Name and Relationship to Student-Athlete