Special Olympics Kansas COVID-19 Clearance Form

If an athlete has tested positive for COVID-19, using a PCR or antigen-based test, he/she must be cleared for progression back to activity by an approved health care provider (MD/DO/PAC/APRN)

Athlete's Name: _____ DOB: _____

Date of Positive Test: _____ Type of Test: _____

Date of Symptom Onset: _____ Date of Symptom Resolution: _____

RETURN TO PLAY IS BASED ON TODAY'S EVALUATION

Date of Evaluation:

Criteria to return (Please check below as applies)

❑ 14 days have passed since symptoms resolved or 10 days from positive test if asymptomatic

❑ 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 YES ❑ NO ❑

Unexplained/excessive dyspnea/fatigue with 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, highly recommend further workup that may include Chest X-ray, EKG/ECHO, Pulmonary Function Tests, Troponins, or Cardiology Consult**

❑ Athlete HAS satisfied the above criteria and IS cleared to start the return to activity progression

❑ Athlete HAS NOT satisfied the above criteria and IS NOT cleared to return to activity

Health Care Provider's Name: _____

Health Care Provider's Address: _____

Office Phone: _____

Health Care Provider's Signature: _____