Black Horse Pike Regional School District

COVID-19 Clearance to Return to Play
MEDICAL PROVIDER ASSESSMENT

Patient Name: _____

Date of Birth: _____ Date of Symptom onset/Positive test: _____

School (please circle): Highland Timber Creek Triton

Please circle the appropriate response to the following questions.

Any **BOLD** answer should warrant further evaluation prior to sports clearance

1.	Has it been at least 14 days since symptom onset or positive test if asymptomatic?	YES	**NO**
2.	Has the patient been afebrile for > 24 hours without use of antipyretics and symptom free > 7 days?	YES	**NO**
3.	Does this patient have any ongoing COVID or cardiovascular symptoms?	**YES**	NO
4.	Does this student have a normal cardiorespiratory exam?	YES	**NO**
5.	Does this person have a normal EKG (if applicable)?	YES	**NO**

I affirm that the above named student is cleared to participate in the following sport(s):
(Name the specific sport, or sports, on the line below)

_____

Health Care Provider Information

Health Care Provider Printed Name:_____

Health Care Provider Signature:_____

Exam Date: _____

Phone: _____ Fax: _____

Provider Office Stamp