Scotia Glenville Central School District

Post SARS-CoV-2 Healthcare Provider Evaluation

If an Athlete tested positive for COVID-19, they must be cleared for activity by a HealthCare Provider

Patient Name:_____DOB:_____

Date symptoms began and ended:_____through_____

Date of positive test: _____

How severe were symptoms:

- ☐ Asymptomatic
- ☐ Mild (<4 days of fever >100°F, short duration of myalgia, chills, and lethargy)
- ☐ Moderate (≥4 days of fever >100°F, myalgia, chills, or lethargy or those who had a non-ICU hospital stay and noevidence of MIS-C)
- ☐Severe (ICU stay and/or intubation or MIS-C)

Physical Examination: Date completed:_____

Cardiac screening including auscultations ☐WNL ☐Abnormal ☐ Cardiac referral

Comments: _____

_____

Return to play (RTP):

Date athlete may RTP:_____

Additional information for RTP:

_____

_____

_____

Provider Name and Address: _____

_____

_____

Provider Signature:_____Date:_____