Chandler Unified School District
COVID-19 Care Report/Release Form

******* <u>This Form Must be Returned to the site COVID-19 Site Lead, Program Lead, or Athletic Trainer to be considered to Return to Participation.</u> *******

Student Name: _____School: _____

Date of Positive Test, Close Contact, or Onset of Signs/Symptoms: _____ Sport/Program: _____

Activity: _____ Location: _____

<u>Check one of the following:</u> To be completed by CUSD Staff.

- ☐ **Student has Signs/Symptoms consistent with COVID-19:** fever of 100.4 or above, new onset or worsening cough, shortness of breath not attributable to underlying cause (e.g., asthma), diarrhea, vomiting, chills, congestion or runny nose, headache, muscle or body aches, nausea, new loss of taste or smell, sore throat. *(circle symptom & see page 2)*

- ☐ **Student has been identified to have been in "close" contact with a positive COVID-19 individual.** (see HCP)

- ☐ **Student has tested positive for COVID-19 or is pending results of a COVID-19 test.** (see HCP)

<u>Evaluation by Healthcare Provider (HCP: PCP or MD/DO):</u> All information below to be completed **HCP only**.

I have reviewed the above COVID-19 report for this student and taken this into consideration in my release. I am familiar and have reviewed the athletes past medical, social, cardiac, and family history and have no concerns with the athlete returning to activity.

<u>This student may</u>: (check the appropriate, and fill in)

_____ *return to activity on _____ (date). Student has completed a 10-day isolation, is symptom free with no fever or has been asymptomatic during isolation from a positive test.*

_____ *return to activity on _____ (date). Student is cleared to return to full activity due to completing a 14-day quarantine and not developing any symptoms.*

_____ *return to activity on _____ (date). Student has an alternate diagnosis or has received a negative COVID-19 test and is now symptom free.*

<u>Is progressive return to play needed?</u> ☐ **Yes** ☐ **No** (Return to participation immediately)

☐ Use AIA Return to Play (RTP) Progression (http://aiaonline.org/files/17128/aia-covid-return-to-play-form.PDF)

Stage	Timing	Activities
Stage 1	2 days minimum	Light activity for 15 minutes or less at an intensity no greater than 70% of maximum heart rate (eg. walking, jogging, stationary bike). No resistance training
Stage 2	1 day minimum	Light activity with simple movement activities (eg. running drills) for 30 minutes or less at an intensity no greater than 80% maximum heart rate. No resistance training
Stage 3	1 day minimum	Progress to more complex training for 45 minutes or less at an intensity of no greater than 80% maximum heart rate. May add light resistance training.
Stage 4	2 days minimum	Normal training activity for 60 minutes or less at an intensity no greater than 80% maximum heart rate
Stage 5		Return to full activity

☐ Healthcare Provider Return To Play: (HCP to provide RTP Plan)

Printed Name of Healthcare Provider:_____ Phone #_____

Healthcare Provider Signature: _____ Date: _____

Form provided by Coach/Employee Signature: _____ Date:_____

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COVID Symptoms Have Not Been Evaluated by Healthcare Provider:

If a student has **ANY ONE** of these following: diarrhea, vomiting, chills, congestion or runny nose, headache, muscle or body aches, nausea, sore throat, e**xclude from activity immediately**. **Student may return to participation when**: symptoms have resolved within first 24 hours AND have remained gone for an additional 24 hours without the use of medication.
* If **ANY** of these symptom(s) above last more than 24 hours student must see a Healthcare Provider. (see page 1)

If a student has **ANY ONE** of these following symptom(s): a fever of 100.4 or above, new onset or worsening cough, shortness of breath not attributable to underlying cause, loss of taste or smell, must be **excluded from activity immediately and must see a Healthcare Provider**. (see page 1)

This student has: To be completed by parent/guardian.

_____*Students symptoms have resolved within first 24 hours AND have remained gone for an additional 24 hours without the use of medication.*

Parent/Guardian Signature: _____ Date: _____

Printed Name of Parent/Guardian:_____ Phone #:_____

Notes:

Site COVID-19 Contact Paperwork Clearance:

Student is cleared to return to participation on (Date): _____

Based on:

- ☐ Completion of page 1

  Or

- ☐ Completion of page 2

Communicate with School Health Office on students return details: _____ *(initial)*

COVID-19 Site Lead/ATC Signature: _____ Date: _____