Hilliard City Schools COVID-19 Return to Activity Clearance Form

If an athlete/patient has tested positive for COVID-19, due to ODH and HCS requirements patient **MUST** have a physician clearance (from MD or DO).

Patient Name _______________________________________ DOB ____________
Date of Symptom Onset ____________________
Date of Positive Test _______________________
Sport/Activity ____________________________
School ____________________________________

Criteria to return to team activity (Please check below as applies):

- At least 10 days have passed since symptom onset/positive test result (if deemed appropriate athlete may begin an individual activity progression on day 6 under guidance of school athletic trainer).
- No fever of >100.4 for 24 hours+ without fever reducing medication and improvement of symptoms.
- Patient was not hospitalized due to COVID-19 infection.

Medical Office Information (Please Print/Stamp)

Physician Name ______________________

Office Address _______________________

Office Phone _________________________

Physician Signature ______________________________ Date of Exam __________________

- Patient **HAS** satisfied above criteria and IS cleared to begin a return to activity progression
- Patient **HAS NOT** satisfied above criteria and IS NOT cleared to return to activity

Return to Activity Progression after COVID-19 Diagnosis

Athletes/patients must complete the progression under the supervision of the OhioHealth athletic trainers at their respective school.

- Patient **HAS** satisfied above criteria and IS cleared to return to activity

Athletic Trainer Signature ___________________________ Date of Exam __________________