THE POTOMAC SCHOOL

# COVID-19 RETURN TO PLAY FORM

**This form must be received before student can return to active exercise.**

Submit form to nurse@potomacschool.org

**STUDENT NAME**__________________________________________**Date of Birth** ___/___/___

**I WAS DIAGNOSED WITH COVID-19 on THIS DATE:** _____/_____/_____

A. Students with a COVID-19 diagnosis are NOT eligible to complete campus COVID-19 PCR testing for 90 days following the diagnosis. However, students must complete this form before returning to campus, indicating their ineligibility.

B. Students with a COVID-19 diagnosis prior to June 20, 2021, ARE eligible and therefore required to complete on-campus COVID-19 testing if they have not been vaccinated. These students must complete this form and participate in Potomac's surveillance testing program as necessary.

C. In accordance with American Academy of Pediatrics, Potomac requires ALL individuals with a past history of COVID-19 to show proof of physical examination and clearance for participation in sports/fitness by a physician.

**PLEASE NOTE:** Any cleared student must complete Return to Play progression under supervision from Athletic Health Services before returning to Potomac Athletics.

**The following statement is REQUIRED to be COMPLETED & SIGNED BY THE EXAMINING PHYSICIAN:**

**The above named student completed a post COVID-19 physical evaluation by me on ___/___/___. Check one:**

☐ The above named student was *evaluated by a primary physician*, was found to be free of any COVID-19 sequelae and is cleared into full athletic, sports, fitness activity without restrictions.

☐ The above named student was found to have possible COVID-19 sequelae and is NOT cleared for any athletic, sports, fitness activity *until further evaluation by cardiology.*

☐ The above named student *was evaluated by cardiology* for possible COVID-19 sequelae and has the following clearance/restriction status (check one):

☐ Restricted by cardiology and is NOT cleared for any athletic/sports/fitness at this time
☐ Cleared by cardiology for full athletic/sports/fitness without restriction
☐ Cleared by cardiology for athletic/sports/fitness with restrictions as follows:

________________________________________________________________

**Provider Name:**
**Provider Signature:**
**Provider Contact:**

Date Form Completed: _____/_____/_____