Self-Assessment for Return to Play After COVID-19

FL / WNY

Patient/Student Name: School:

Date of Birth: Age:

Which sport (if any) is your child returning to:

Primary Care Physician's name:

Date COVID symptoms started (if known): _____

Date COVID positive test was taken: _____

Date the child's symptoms (other than loss of taste or smell) went away:_____

Did/was the child:

Have a fever of 100.4° or higher for 4 days or more?	No	Yes
Have chills, body aches for 7 days or more?	No	Yes
Very tired for 7 days of more?	No	Yes
Have to stay in the hospital because of COVID symptoms?	No	Yes
Admitted to the Intensive Care Unit (ICU) in the hospital, intubated, or diagnosed with Multisystem Inflammatory Syndrome (MIS-C)?:	No	Yes

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In the last 24 hours has the child had:

Chest pain at rest or with activity?	No	Yes
Shortness of breath?	No	Yes
Excessive fatigue/tiredness with activity?	No	Yes
Skipped heart beats or a heartbeat not normal for the child?	No	Yes
Fainting or passing out that is not normal for the child?	No	Yes

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If you answered yes to any of the above questions, please call your child's doctor to schedule a visit and do not have them re-start physical activity until cleared to do so.

By signing below, I confirm that the answers to the questions on this form are true to the best of my knowledge.

Parent Signature Date

v.1/31/22