CENTENNIAL SCHOOL DISTRICT

Athlete Return to Participation Form

To be completed by athlete's PCP, Team Physician or Cardiologist (Complete all parts)

Name: _____ DOB: _____

Date of diagnosis: _____ Symptoms: ☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE

Onset of symptoms (date): _____ Date of symptom resolution: _____

Did the athlete self-isolate for ten (10) days?	Yes	No
Has the athlete been fever free for the last 24 hours without medication?	Yes	No
Have symptoms been improving?	Yes	No
Was an EKG performed?	Yes	No
If yes: Was the EKG normal?	Yes	No
Were cardiac labs performed (high sensitivity-Troponin, BNP, CRP)?	Yes	No

If yes, results: _____

Was cardiac imaging (Echo, Cardiac MRI) performed?	Yes	No

If yes, results: _____

Was the athlete referred to Cardiology?	Yes	No
Is the athlete CLEARED to start a GRADUATED return to sports:	Yes	No

Please list any RESTRICTIONS for return to sport: _____

_____

Name of clearing physician: _____ Date: _____

Physician's Signature: _____ MD / DO License Number: _____