Hartford HealthCare
Sports Medicine

Name: _____ Date of Positive Test: _____
Sport _____ Date of Return to School: _____

Returning to Athletics Following COVID-19 Infection:

Hartford HealthCare and the West Hartford Public Schools continue to review the infection data and risk concerning COVID-19 infections as it pertains to the health and safety of its student athletes. In response to the 2/10/22 approval, the CT Department of Public Health has endorsed the CIAC's request to adopt the return to play guidelines from the National Federation of State High School Association (NFHS) and American Medical Society for Sports Medicine (AMSSM) joint statement, updated January 2022. The following questionnaire is a tool to inform the parents and student athlete on the individual clearance needs for the student athlete following a positive COVID-19 infection. This will be reviewed by the medical staff at the school to best provide the student athlete with a safe return to athletics.

Please answer the following: Since time of infection or positive case, have you experienced any of the following:

1.	Nasal Congestion (runny nose)	Yes	No	Duration: _____
2.	Sneezing	Yes	No	Duration:_____
3.	Sore throat	Yes	No	Duration: _____
4.	Chills or Fever (>100.4^{o}F)	Yes	No	Duration: _____
5.	Loss of Taste or Smell	Yes	No	Duration:_____
6.	Vomiting or Diarrhea	Yes	No	Duration: _____
7.	Headache	Yes	No	Duration: _____
8.	Fatigue or feeling of weakness	Yes	No	Duration: _____
9.	Chest pain	Yes	No	Duration: _____
10.	Shortness of Breath or difficulty breathing	Yes	No	Duration: _____
11.	Syncope (fainting)	Yes	No	Duration: _____
12.	Heart Palpitations	Yes	No	Duration: _____

If you did not experience any symptoms or answered **YES** to questions 1-3 **AND** the symptoms lasted less than 2 days, you are considered to have experienced an **ASYMPTOMATIC OR MILD ILLNESS**. The return to play protocol is as follows:

- Follow up with school athletic trainer, provide a copy of this form.
- Athletic trainer will perform their evaluation and begin the individualized graduated return to play progression.

If you answered **YES** to questions 1-3 **AND** the symptoms lasted more than 2 days **OR** you answered **YES** to questions 4-12, you are considered to have experienced a **MODERATE ILLNESS OR INITIAL CARDIOPULMONARY SYMPTOMS**. The return to play protocol is as follows:

- Schedule evaluation with Primary Care Provider
- Obtain written clearance to return to athletics from Primary Care Provider and provide to school nurse and/or athletic trainer.
- Follow up with school athletic trainer, provide copy of this form.
- Athletic Trainer will perform evaluation and begin the individualized graduated return to play progression.

If the student athlete experiences any cardiopulmonary symptoms with their return to exercise (questions 9-12), exercise will discontinue and the athlete will be referred to their primary care provider for a cardiology evaluation. This athlete will need medical clearance prior to returning to any activity.

_____ _____ _____

Parent/Guardian (Print) Parent/Guardian (Signature) Date