



COVID-19 RETURN TO PLAY FORM:

COVID-19 INFECTION MEDICAL CLEARANCE RELEASING THE STUDENT-ATHLETE TO RESUME FULL PARTICIPATION IN ATHLETICS

This form must be signed by one of the following examining Qualified Healthcare Professionals (QHP) before the student-athlete is allowed to resume full participation in athletics: Licensed Physician (MD/DO), Licensed Physician Assistant (PA), Licensed Nurse Practitioner (NP). This form must be signed by the student-athlete's parent/legal custodian giving their consent before their child resumes full participation in athletics.

Name of Student-Athlete:	DOB:	Male/Female
Date COVID-19 Infection Diagnosed:	Date COVID-19 Infect	ion Resolved:
This is to certify tha	at the above-named student-a	thlete
has been diagnosed	and treated for COVID-19 infec	ction.
As the examining QHP, I attest that the above free of all signs and symptoms of COVID-19 a cardiopulmonary diagnostic studies. By signing consent to resume full participation in athletic	nd has had negative results on ng below therefore, I give the a	all the appropriate
Signature of Licensed Physician, Licensed Physician A Licensed Nurse Practitioner (Please Circle)	Assistant,	Date
Please Print Name		
Please Print Office Address	s -	Phone Number

I am aware that the DIAA REQUIRES the coresuming full participation in athletics after hacknowledge that the Qualified Healthcare PCOVID-19 infection care and has given their of By signing below, I hereby give my consent for	onsent of a child's parent or lawing been diagnosed and trea Professional above has oversee Consent for my child to resume	egal custodian prior to them ted for a COVID-19 infection. In the treatment of my child's a full participation in athletics.
Signature of Parent/Legal Cus	todian	Date
Please Print Name and Relationship to Stud	Jent-Athlete	