Cardinal O'Hara HIGH SCHOOL

Athletics Return to Play after Covid Assessment Form

To be completed by the student's parent/guardian

Student: _____ Date of Birth: _____

Sport returning to: _____

Healthcare Provider: _____

Date COVID symptoms started: _____

Date of positive COVID test: _____

Date symptoms ended (not including loss of taste/smell): _____

Answer the following questions regarding your child's symptoms:

Did they have a fever of 100.4°F for 4 days or more? No _____ Yes _____
Did they have chills or body aches for 7 days or more? No _____ Yes _____
Were they very tired for 7 days or more? No _____ Yes _____
Were they hospitalized because of COVID symptoms? No _____ Yes _____
*If YES, were they in the ICU, intubated, or diagnosed with Multisystem Inflammatory Syndrome (MIS-C)? No _____ Yes _____

In the past 24 hours, has your child had any of the following symptoms:

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 heartbeat not normal? No _____ Yes _____
Fainting or passing out (that is not normal for them)? No _____ Yes _____

If you answered YES to any of the above questions, please call your child's healthcare ***provider to schedule a visit and do not have them resume physical activity or sports until cleared to do so by their provider.***

By signing, I confirm the answers to the questions are true to the best of my knowledge:

_____ _____

Parent/guardian signature Date

Based on the WNY COVID Return to Play Group recommendations 2022