

Onteora Central School District
COVID Activity Clearance Form
COVID-19 Diagnosis

Student Name: _____

DOB: _____ **Sport:** _____

Health Care Provider Name (Please Print): _____

Date of onset of COVID symptoms:

Date of COVID positive test:

Date of resolution of COVID symptoms

Symptoms longer than 4 days? _____ No _____ Yes

Hospitalization due to COVID symptoms? _____ No _____ Yes

History of Cardiac abnormalities or followed by cardiology _____ No _____ Yes

Recent Symptoms:

Chest pain at rest or with exertion? _____ No _____ Yes

Shortness of breath with minimal activity? _____ No _____ Yes

Excessive fatigue with exertion? _____ No _____ Yes

Abnormal heartbeat or palpitations? _____ No _____ Yes

Syncope or near-syncope? _____ No _____ Yes

Exam

Normal exam? _____ No _____ Yes

Normal Cardiovascular exam? _____ No _____ Yes

EKG completed? _____ No _____ Yes

Referral to Cardiology _____ No _____ Yes

Clearance

Cleared for sports/return to play, _____ No _____ Yes

Gradual return Progression Protocol required _____ No _____ Yes

Healthcare Provider Signature

Printed Name or Stamp

Date

PLEASE RETURN COMPLETED FORM TO SCHOOL NURSE AS SOON AS POSSIBLE: FAX 845-657-8430