# RETURN TO SCHOOL & ATHLETICS FORM

The student below is being released back to school, physical education, and athletics following an:

☐ ILLNESS (If absent 3 or more day or at nurse's request) ☐ ILLNESS (COVID diagnosis) ☐ INJURY

Student's Name: ______________________ DOB: ______________

Diagnosis: ______________________ Date of Diagnosis: ______________

Date Symptoms Resolved (If applicable): ______________________

**Criteria to Return Post Covid (Please check below as applies)**

☐ 5 days have passed since symptoms first appeared and symptoms have resolved (No fever (⩾ to 100.4 F) for 24 hours without fever reducing medication, improvement of symptoms, (cough, shortness of breath, etc.) OR was asymptomatic for 5 days following positive test.)

☐ Student was not hospitalized due to COVID-19 infection.

☐ Cardiac screen negative for myocarditis/myocardial ischemia (All answers below must be no)

| | | |
|---|---|---|
| Chest pain/tightness with exercise | YES ☐ | NO ☐ |
| Unexplained syncope/near syncope | YES ☐ | NO ☐ |
| Unexplained/excessive dyspnea/fatigue w/exertion | YES ☐ | NO ☐ |
| New palpitations | YES ☐ | NO ☐ |
| Heart murmur on exam | YES ☐ | NO ☐ |

**NOTE:** If any cardiac screening question is positive or if student was hospitalized, consider further workup as indicated. May include CXR, Spirometry, PFTs, Chest CT, Cardiology Consult.

☐ I release the above-named student to return to school, PE, and athletics following an illness.

☐ I release the above-named student to return to school, PE, and athletics following an injury.

______________________ Physician's Signature ______________ Date

______________________ Please Print Name ______________ Phone Number

______________________ Please Print Office Address

**Medical Office Stamp**

# RETURN TO SCHOOL & ATHLETICS FORM (Continued)

**Parent/Legal Custodian Consent:**

- I am aware that Dwight Englewood REQUIRES that students that are absent more than 3 days due to illness or injury, must provide a medical release from a Licensed Physician, MD of Osteopathic Medicine, Licensed Physician Assistant, or Licensed Nurse Practitioner before returning to school.

- I acknowledge that the Licensed Health Care Provider listed above has provided medical care to my child.

By signing below, I hereby give my consent for my child to return to school following an illness/injury.

____________________________________ ____________________
Signature of Parent/Legal Custodian | Date

____________________________________________________
Please print name and relationship to student