Charter School for Applied Technologies

www.csat-k12.org

Athletics Return to play after COVID Assessment form

To be completed by the student's parent/guardian

Student:_____ Date of Birth:_____

Sport returning to:_____

Health Care Provider:_____

Date of Covid symptoms started:_____

Date of Positive COVID test:_____

Date symptoms ended:_____

Answer the following questions regarding your child's symptoms

Did they have a fever of 100.4 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 heartbeats or heartbeat not normal? No_____ Yes_____
Fainting or passing out? No_____ Yes_____

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

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

Parent/Guardian_____ **Date**_____