FL/WNY Self-Assessment for Return to Play After COVID-19

Patient/Student Name: School:

Date of Birth: Age:

Which sport (if any) is your child returning to:

Primary Care Physician [• v :u

Date COVID symptoms started (if known): ___________________

Date COVID positive test was taken: ____________________

š š Z Z] ptoms (other than loss of taste or smell) went away:___________________

Did/was the child:

Have a fever of 100.4° or higher for 4 days or more? No Yes

Have chills, body aches for 7 days or more? No Yes

Very tired for 7 days of more? No Yes

-C)?: No Yes

In the last 24 hours has the child had

Chest pain at rest or with activity? No Yes

Shortness of bre0.08bre0.08bre0.0F1 yy0t/F1 10.61 0 0 1 494.74 26.6m0 [3)]TT(t)52nes.6f bre0.08bre0.0il9 Yes

Excessive fatigue/tiredness with activity? No Yes

Skipped heart beats or a heartbeat not normal for the child? No Yes

Fainting or passing out that is not normal for the child? No Yes

---

If you answered yes to any of the above questions, please F D O O \ R X U F K L to schedule a F W R U visit and do not have them re -start physical activity until cleared to do so .

By signing below, I confirm that the answers to the questions on this form are true to the best of my knowledge .

Parent Signature 792 reW*nBT/F1 1910( )-3( )9( )-3( )9( )-3(7