Screening History for Return to Exercise Clearance in Patients aged 6-20 years after COVID-19 Infection

Name: ____ DOB: _____________________

Isolation Release Date: _____________ Date Afebrile (off fever-reducing medication): ________________

Current Temp Reading:________________

Symptoms during infection with duration: ____

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Severity (Circle One)			
Asymptomatic	Mild	Moderate	Severe
+ test only **ANSWER QUESTIONS BELOW**	Fever < 4 days or systematic symptoms* < 1 week **ANSWER QUESTIONS BELOW**	Fever ≥ 4 days or systematic symptoms* ≥ 1 week **REQUIRES CLEARANCE BY PRIMARY CARE PROFESSIONAL (PCP)**	Hospitalized (including MIS-C) **REQUIRES CLEARANCE BY PCP/ ENSURE INVOLVEMENT OF PEDIATRIC CARDIOLOGY**

**Fever is T > 100.4 F. Systemic symptoms include chills, congestion, GI symptoms, headache, lethargy, myalgia*

Following Resolution of acute COVID-19 infection, has the patient had:		
Chest pain/discomfort/tightness/pressure	YES □	NO □
Unexplained syncope or near syncope	YES □	NO □
Unexplained shortness of breath or fatigue	YES □	NO □
Palpitations	YES □	NO □

If <u>YES</u> to any of the above → refer to PCP for in person evaluation

If the severity is <u>asymptomatic or mild,</u> the patient has been <u>afebrile for 24 hours</u> (without fever reducing medications), AND all of the above are <u>NO</u>,

- **begin participation in a supervised Gradual Return to Play (RTP) program AND**
- **complete questions on next page**

Heart Health History Questions:		
Known significant heart disease **(refer to PCP if not already documented on a Pre-participation Evaluation (PPE) form)**	YES □	NO □
Have you ever passed out or nearly passed out during or after exercise?	YES □	NO □
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	YES □	NO □
Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	YES □	NO □
Has a doctor ever told you that you have any heart problems?	YES □	NO □
Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography	YES □	NO □
Do you get light-headed or feel shorter of breath than your friends during exercise?	YES □	NO □
Have you ever had a seizure?	YES □	NO □
History of elevated systemic blood pressure	YES □	NO □
Prior restriction from participation in sports	YES □	NO □
Prior cardiac testing ordered by a physician	YES □	NO □
Family history of premature death <50yrs due to heart disease	YES □	NO □
Disability due to heart disease in a close relative <50yo	YES □	NO □
Family history of HCM/dilated cardiomyopathy, long QT/ion channelopathies, Marfan Syndrome, significant arrhythmias, or genetic cardiac conditions	YES □	NO □
History of heart murmur (excluding innocent/resolved murmurs)	YES □	NO □

If YES to any of the above AND not already addressed as documented on PPE form

- ➔ **do NOT allow resumption of competition (may continue RTP) until cleared by PCP (in person or by documentation)**

If NO to all of the above

- ➔ **send a copy of this form to the patient's PCP for their records**

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Athletic Trainer Name (Printed) Athletic Trainer Signature Date