



**RETURN TO PLAY FORM:
AFTER ACKNOWLEDGEMENT
OF COVID-19 SYMPTOMS**

This form must be signed by one of the following examining Licensed Health Care Providers (LHCP) before the student-athlete is allowed to resume full participation in athletics: Licensed Physician (MD/DO), Licensed Physician Assistant (PA), Licensed Nurse Practitioner (NP). This form must be signed by the student-athlete’s parent/legal custodian giving their consent before their child resumes full participation in athletics.

Name of Student-Athlete: _____ DOB: _____ Male/Female

Date COVID-19 Symptom Diagnosed: _____ Date COVID-19 Symptom Resolved: _____

After having acknowledged sign(s)/symptom(s) consistent with COVID-19, and as the examining LHCP, I certify and attest that the above-named student-athlete had a negative test result **OR** that the symptoms were not related to COVID-19.

Therefore, by signing below, I release the above-named student-athlete to resume full participation in athletics.

Signature of Licensed Physician, Licensed Physician Assistant,
Licensed Nurse Practitioner (Please Circle)

Date

Please Print Name

Please Print Office Address

Phone Number

Parent/Legal Custodian Consent for Their Child to Resume Full Participation in Athletics

I am aware that the NCHSAA **REQUIRES** the consent of a child’s parent or legal custodian prior to them resuming full participation in athletics after acknowledgement of sign(s)/symptom(s) consistent with COVID-19. I acknowledge that the Licensed Health Care Provider above has overseen my child’s negative COVID-19 test or indicated that the symptoms were not related to COVID-19. Subsequently, I acknowledge that the Licensed Health Care Provider above has released my child to resume full participation in athletics. By signing below, I hereby give my consent for my child to resume full participation in athletics.

Signature of Parent/Legal Custodian

Date

Please Print Name and Relationship to Student-Athlete