COVID-19 Return To Play For Performance Athletes Protocol

Coronavirus disease 2019 (COVID-19) is associated with significant mortality and morbidity, including adverse cardiovascular sequelae. The American College of Cardiology's Sports & Exercise Cardiology Council, American Medical Assoiciation, and the American Academy of Pediatrics provided a consensus expert clinical framework on return to play in the era of COVID-19. Myocarditis can happen from the virus which could result in cardiac dysfucntion, arrhythmias, and death.

This protocol is for all performance athletes who have tested negative or positive for COVID-19 and are asymptomatic or have symptoms themselves. All performance athletes will go through this protocol to return to play for their designated sport(s). The progression of the protocol is described below:

COVID -19 Negative and Asymptomatic

- No limitations to exercise
- Close monitoring for development of symptoms

COVID-19 Positive and Asymptomatic

- See Physician to be cleared to start graudated return to play protocol
- Return the Positive COVID Clearance/Physician Referral Form to school athletic trainer
- Close monitoring of symptom onset or late deterioration
- Slow resumption of activity following the graduated return to play protocol under the guidance of health care team

COVID-19 Positive and Mild Symptoms

- During symptomatic period: rest and no exercise.
- Close monitoring of symptoms
- Evaluation by a physician (MD/DO) to consider further cardiac screening (hsTn, ECG, echocardiagram) and to get clearance to begin graduate return to play protocol.
- Return the Positive COVID Clearance/Physician Referral Form to school athletic trainer
- Slow resumption of activity following the graduated return to play protocol under the guidance of health care team

COVID-19 Positive and Significant Symptoms/hospitalization

- Evaluation by a physician and further cardiac testing/imagining if not done while hospitalized. Physician clearance to begin graduate return to play protocol.
- During symptomatic period: rest and no exercise.
- Close monitoring of symptoms
- Return the Positive COVID Clearance/Physician Referral Form to school athletic trainer
- Slow resumption of activity following the graduated return to play protocol under the guidance of health care team

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Positive COVID Clearance/Physician Referral Form

This athlete has indicated that he/she has contracted or come in contact with COVID-19. We are requiring a Signature AND Stamp from a medical provider that clears him/her from isolation and/or quarantine. This form is a risk assessment tool to evaluate eligibility to return to athletic related activity and must be completed by a physician and returned to school athletic trainer. Please include any other medical documentation regarding care/treatment received for COVID19. The symptoms below are based on guidelines from the Center for Disease Control and Prevention (CDC).

Athlete Name: ______________________ **Sport:** ______________

Indicated Positive for COVID-19 on: ______________ **Date of Physician Visit:** ______________

Indicated Symptoms:

- ☐ Known close contact with person who is lab confirmed for COVID-19
- ☐ Fever
- ☐ Body Chills
- ☐ Extreme level of fatigue
- ☐ Cough
- ☐ Pain/ difficulty breathing
- ☐ Shortness of breath
- ☐ Sore throat
- ☐ Body/ muscle aches
- ☐ Loss of taste
- ☐ Loss of smell
- ☐ Changes to vision/eye discharge
- ☐ Diarrhea
- ☐ Unexplained headache

Start Date of reported symptoms: ______________ **End Date of reported symptoms:** ______________

Other Comments/Observations: ______________________________

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TO BE COMPLETED BY PHYSICIAN:

______________ (name of student-athlete) has completed the current public health guidance requirements via time-based strategy (10 days from symptom onset AND 24 hours from symptom resolve; fever without use of fever reducing medications, respiratory symptoms). ☐ YES ☐ NO

Has been released from isolation and/or quarantine and is allowed to return to school and start the graduated return to play stages. ☐ YES ☐ NO

Has completed cardiac testing (via physical exam, ECG/EKG, hsTN, and/or cardiac imaging) and is cleared of any cardiac concern. ☐ YES ☐ NO

Cardiac Testing Completed, Testing Results/Comments/Recommendations: ______________________________

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Sports Participation Status: (Please initial your recommendation below)

________ May start return to play protocol and return to FULL sports participation once completed (No limitations)

________ May start return to play protocol and LIMITED sports participation once completed. Limitations to be listed here: ______________________________

________ May NOT return to sports participation at this time.

Physician Name (Printed): ______________________ Phone: ______________

Physician Signature: ______________________ Date: ______________

Return this for to your school's athletic trainer

After the athlete has been cleared by their physician (MD/DO) to start the graduated return to play stages, they will follow the below Graduated Return to Play Stages under the supervision of their school's athletic trainer:

COVID-19 Graduated Return to Play Stages

	Stage 1 10 Days Minimum	**Stage 2** 2 Days Minimum	**Stage 3A** 1 Day Minimum	**Stage 3B** 1 Day Minimum	**Stage 4** 2 Days Minimum	**Stage 5** Earliest Day 17	**Stage 6**
Activity Description	Minimum Rest Period	Light Activity	Frequency of Training Increases	Duration of Training Increases	Intensity of Training Increases	Resume Normal Training	**RETURN TO COMPETITION**
Exercise Allowed	Walking, Daily Living Activities	Walking, light jogging, stationary biking	Simple Movement Acitivities (Running Drills)	Progression to more complex Training Activities	Normal Training Activities	Resume Normal Training	
% Heart Rate Max		< 70%	< 80%	< 80%	< 80%	Resume Normal Training	
Duration	10 Days	< 15 minutes	< 30 minutes	< 45 minutes	< 60 minutes	Resume Normal Training	
Objective	Allow Recovery Time	Increase Heart Rate	Increase load gradually	Exercise, coordination and skills/tactics	Restore confidence and assess functional skills	Resume Normal Training	

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Indicated Positive for COVID-19 on: ____________________ **Date of Physician Visit:** ____________________

Indicated Symptoms:

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- ☐ Loss of taste
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- ☐ Changes to vision/eye discharge
- ☐ Diarrhea
- ☐ Unexplained headache

Start Date of reported symptoms: ____________________ **End Date of reported symptoms:** ____________________

Other Comments/Observations: ____

____

TO BE COMPLETED BY PHYSICIAN:

____________________ (name of student-athlete) has completed the current public health guidance requirements via time-based strategy (10 days from symptom onset AND 24 hours from symptom resolve; fever without use of fever reducing medications, respiratory symptoms). ☐ YES ☐ NO

Has been released from isolation and/or quarantine and is allowed to return to school and start the graduated return to play stages. ☐ YES ☐ NO

Has completed cardiac testing (via physical exam, ECG/EKG, hsTN, and/or cardiac imaging) and is cleared of any cardiac concern. ☐ YES ☐ NO

Cardiac Testing Completed, Testing Results/Comments/Recommendations: ____________________

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Sports Participation Status: (Please initial your recommendation below)

__________ May start return to play protocol and return to **FULL** sports participation once completed (No limitations)

__________ May start return to play protocol and **LIMITED** sports participation once completed. Limitations to be listed here: ____

__________ May **NOT** return to sports participation at this time.

Physician Name (Printed): ______________________________ Phone: ____________________

Physician Signature: ______________________________ Date: ____________________

Return this for to your school's athletic trainer