



RETURN TO PLAY FORM:

COVID-19 NEGATIVE TEST RESULT MEDICAL CLEARANCE RELEASING THE STUDENT-ATHLETE TO RESUME FULL PARTICIPATION IN ATHLETICS

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 Symp	otom Resolved:
This is to certify that the above-named stracknowledged sign(s)/syr	udent-athlete had a negativn nptom(s) consistent with Co	_
As the examining LHCP, I attest that the above having acknowledged sign(s)/symptom(s) consthe above-named student-athlete consent to re-	istent with COVID-19. By s	igning below therefore, I give
Signature of Licensed Physician, Licensed Physician Assis Licensed Nurse Practitioner (Please Circle)	tant,	Date
Please Print Name		
Please Print Office Address		Phone Number

Parent/Legal Custodian Consent for The I am aware that the NCHSAA REQUIRES the coresuming full participation in athletics after have consistent with COVID-19. I acknowledge that child's negative COVID-19 test and has given athletics. By signing below, I hereby give my co	insent of a child's parent or ving tested negative for ackr the Licensed Health Care Pro their consent for my child t	legal custodian prior to them nowledged sign(s)/symptom(s) povider above has overseen my to resume full participation in
Signature of Parent/Legal Custodi	an	Date
Please Print Name and Relationship to Studen	nt-Athlete	