Final

Ohio High School Athletic Association
4080 Roselea Place
Columbus, Ohio 43214
614-267-2502
www.ohsaa.org

MEDICAL AUTHORIZATION TO RETURN TO PLAY WHEN A STUDENT HAS BEEN INFECTED WITH COVID-19

In accordance with the Ohio Department of Health Director's Sports Order amended and issued September 25, 2020, that provides MANDATORY requirements for interscholastic sports, any student-athlete who tests positive for COVID-19, whether symptomatic or asymptomatic, shall not return to sports activities until a documented medical exam is performed clearing the individual prior to that individual returning to contests or practices. The documented medical exam must specifically include an assessment of the cardiac/heart risk of high intensity exercise due to the potential of myocarditis occurring in COVID-19 patients. This **written medical authorization from a physician (M.D. or D.O.)** or another qualified licensed medical provider, who works in consultation with, collaboration with or under the supervision of an M.D. or D.O. or who is working pursuant to the referral by an M.D. or D.O., AND is authorized by the Board or Education or other governing board, **is being required by our school/school district to grant written clearance for the student to return to participation**.

This form shall serve as verification that the physician or licensed medical professional has examined the student, has performed a specific cardiac/heart risk evaluation or has referred the student for more definitive evaluation by a specialist. The physician or licensed medical professional must complete this form and submit to a school administrator prior to the student's resumption of participation in practice and/or a contest. **To reiterate, this student is not permitted to reenter practice or competition until cleared by a physician or licensed medical provider.**

I, ____, M.D., D.O. or other qualified licensed medical provider,
(Print name of MD, DO or Other)

have examined the following student:

____ from ____.
(Name of Student) (High School/7th-8th Grade School)

I have examined this student and determined that he/she is:

___ Cleared to return to participation

___ Not Cleared and Referred to a cardiologist or other specialist

___ Return to play clearance is limited to the following sport(s):____

<u>Signature of Medical Professional:</u>

____
(MD, DO or other qualified Licensed Medical Provider as Approved in the Above Directive)

Date: ______________________________________ Phone: _____________________________________

Address:____
(Print or Stamp Address)

VALID ONLY WITH ALL INFORMATION COMPLETED
FOR SCHOOL USE ONLY- DO NOT SEND TO OHSAA OFFICE