

COVID-19 Return to Play Form

According to Montana High School Association guidelines “Any MHSAA activity participant who has been diagnosed with COVID-19 cannot return to play until he/she is evaluated by a licensed healthcare professional, and has written clearance to return to play from a licensed healthcare professional. The participant must also be cleared from isolation by the county health department.”

Athlete's Name: _____ DOB: _____

Date of Positive Test: _____ Date of Symptom Onset: _____

Date of Symptom Resolution: _____ Date of Evaluation: _____

There are still many unknowns about the effects of COVID-19 on athletes and when it's safe for youth to return to sports after an infection. Although it seems to be less common in children than adults, COVID-19 is known to cause cardiac damage and heart inflammation (myocarditis). Additionally, myocarditis is recognized as a cause of sudden death in young athletes. Given these uncertainties, the following return to play recommendations were created based on expert opinion from Montana pediatric cardiologists and national guidelines (see attached guidance). These recommendations are subject to change as research and recommendations evolve.

Criteria to return

- Complete isolation period, AND;
- Athlete was not hospitalized and did not experience SEVERE illness (hospitalization, ICU stay, MIS-C) due to COVID-19 infection, AND;
- Negative AHA 14-element cardiac screen with emphasis on the following myocarditis symptoms (all answers below must be no):
 - Chest pain/tightness with exercise YES NO
 - Unexplained syncope/near syncope YES NO
 - Unexplained/excessive dyspnea/fatigue w/exertion YES NO
 - New palpitations YES NO
 - Heart murmur on exam YES NO
- Complete physical exam was performed and normal if athlete had moderate illness (>4 days of fever >100.4, OR > 1 week myalgias, chills, and/or lethargy)
- EKG was performed and normal IF athlete had moderate illness (>4 days of fever >100.4, OR > 1 week myalgias, chills, and/or lethargy)”

***NOTE: If any of the above criteria to return are not met, EKG, pediatric cardiology consultation and further workup may be required. See decision tree attached.**

- Athlete HAS satisfied the above criteria and IS cleared to start a graduated return-to-play protocol (see attached guidance).
- Athlete HAS NOT satisfied the above criteria and IS NOT cleared to return to activity until pediatric cardiology has been consulted.

Evaluator's Name: _____

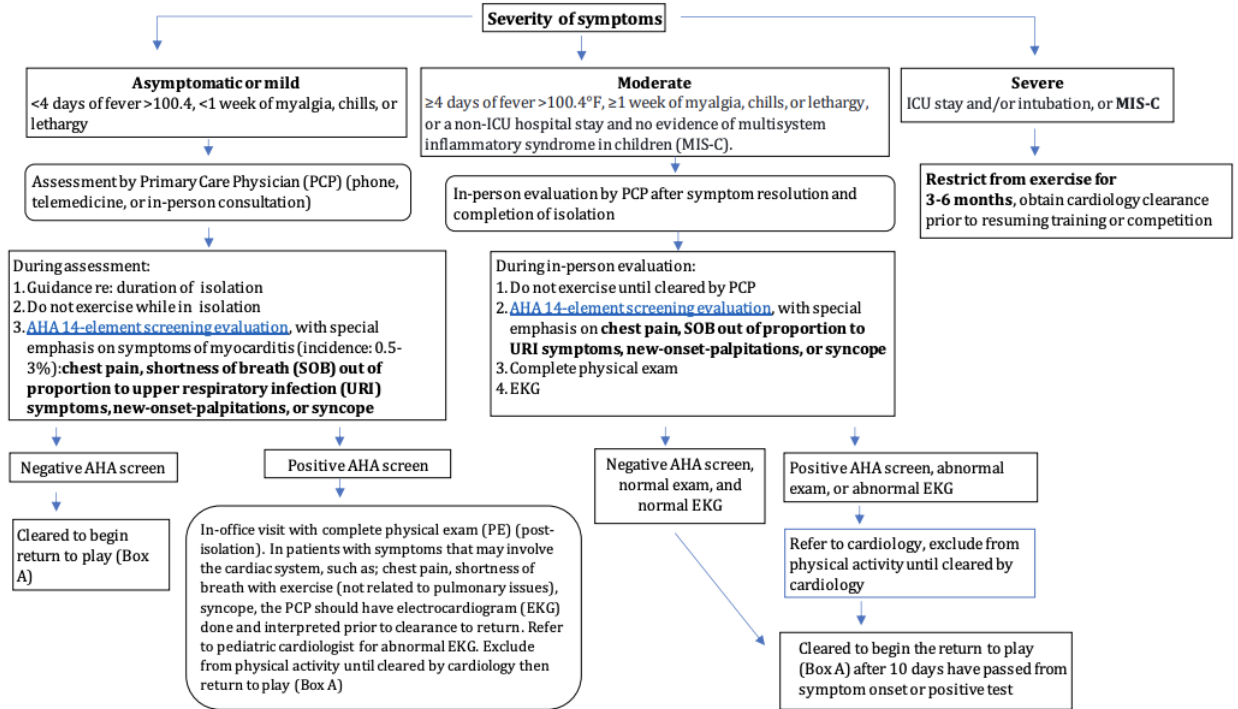
Office Phone: _____

Evaluator's Signature: _____

Date: _____

Return to play after COVID-19 infection

Adapted from the AAP COVID-19 Interim Guidance: Return to Sports and Physical Activity by Anna Zuckerman, MD, FAAP and Jonathan Flyer, MD, FAAP, FACC. For detailed guidance, please refer to the [AAP COVID-19 Interim Guidance: Return to Sports and Physical Activity](#). (last updated 1/20/2022)



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BOX A: Additional Guidance on Returning to Play (Note: if the patient has already advanced back to physical activity on their own and is without abnormal cardiovascular signs/symptoms, then no further evaluation is necessary. COVID19 disease history should be documented.)

When should children and adolescents return to play?

- 1) Completed isolation and minimum amount of symptom free time has passed
- 2) Can perform all activities of daily living
- 3) No concerning signs/symptoms
- 4) Physician clearance has been given, if indicated

At what pace should children and adolescents return to play?

- 5) <12yo: progress according to own tolerance
- 6) 12+: gradual return to physical activity
 - o Asymptomatic / Mild symptoms: Minimum 1 day symptom free (excluding loss of taste / smell), 2 days of increase in physical activity (i.e. one light practice, one normal practice), no games before day 3. A mask is required for ALL physical activity, including games or scrimmages, until 10 full days from + test or symptom onset have passed.
 - o Moderate symptoms: Minimum 1 day symptom free (excluding loss of taste / smell), and a minimum of 4 days of gradual increase in physical activity (one light cardio workout on own, two light practices, one full practice), no games before day 5. A mask is required for ALL physical activity, including games or scrimmages, until 10 full days from + test or symptom onset have passed.

When should children and adolescents pause return to play?

- If patient develops any chest pain, SOB out of proportion to URI infection, new-onset palpitations, or syncope when returning to exercise, immediately stop and go to PCP for in-person exam and consider referral to Pediatric Cardiology

The 14-Element AHA Cardiovascular Screening Checklist for Congenital and Genetic Heart Disease

Personal history

Yes No

- 1. Chest pain/discomfort/tightness/pressure related to exertion
- 2. Unexplained syncope/near-syncope*
- 3. Excessive exertional and unexplained dyspnea/fatigue or palpitations, associated with exercise
- 4. Prior recognition of a heart murmur
- 5. Elevated systemic blood pressure
- 6. Prior restriction from participation in sports
- 7. Prior testing for the heart, ordered by a physician

Family history

Yes No

- 8. Premature death (sudden and unexpected, or otherwise) before age 50 attributable to heart disease in ≥ 1 relative
- 9. Disability from heart disease in close relative < 50 y of age
- 10. Hypertrophic or dilated cardiomyopathy, long-QT syndrome, or other ion channelopathies, Marfan syndrome, or clinically significant arrhythmias; specific knowledge of certain cardiac conditions in family members

Physical Examination

Yes No

- 11. Heart murmur**
- 12. Femoral pulses to exclude aortic coarctation
- 13. Physical stigmata of Marfan syndrome
- 14. Brachial artery blood pressure (sitting position)***

**Judged not to be of neurocardiogenic (vasovagal) origin; of particular concern when occurring during or after physical exertion.*

***Refers to heart murmurs judged likely to be organic and unlikely to be innocent; auscultation should be performed with the patient in both the supine and standing positions (or with Valsalva maneuver), specifically to identify murmurs of dynamic left ventricular outflow tract obstruction.*

****Preferably taken in both arms.*