SALESIAN HIGH SCHOOL

This form must be signed by the following examining health care professional before the student-athlete is allowed to resume full participation in athletics: **Licensed Physician (MD/DO), Licensed Physician Assistant (PA) or 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:		**Date of Birth:**	
Date COVID-19 Infection Diagnosed:		**Date COVID-19 Infection Resolved:**	

This is to certify that the above named student athlete has been diagnosed and treated for COVID-19 infection.

As the examining HP, I attest that the above-named student-athlete is now reporting to be completely free of all signs and symptoms of COVID-19 and has no noted cardiac issues, and/or had negative results on all the appropriate cardiopulmonary diagnostic studies if needed. By signing below, I give the above named student-athlete consent to resume full participation in athletics.

Print Name	
Signature of Licensed Physician, Licensed Physician Assistant, Licensed Nurse Practitioner (Please Circle Your Title)	
Print Office Address	**Phone Number**

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Parent/LegalCustodian Consent For Their Child to Resume Full Participation in Athletics

I acknowledge that the Healthcare Professional above has overseen the treatment of my child's COVID-19 infection care and has given their consent for 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.

Print Name of Parent/Legal Guardian	
Signature of Parent/Legal Guardian	**Date**