Hawken Return to Activity Form

In keeping with the recommendations of local cardiologists and the American Academy of Pediatrics, Hawken has developed the following protocol for students who have tested positive for or have been diagnosed with COVID-19:

ALL students are required to have a clearance letter from a physician before starting the Return to Activity protocol. This letter needs to indicate that a pre-participation screening evaluation with special emphasis on cardiac symptoms has been performed. (Form on reverse side)

1. If asymptomatic – self-isolation, rest and no exercise for 10 days from the time of the positive test. Follow Return to Activity protocol.

2. If symptomatic - self-isolation, rest and no exercise for 10 days from the time of symptom onset and a minimum of 24 hours symptom free and off fever reducing medications. Follow the Return to Activity Protocol.

3. Return to Activity Protocol which includes (return to activity will be tailored to baseline ability and sport returning to):

   a. **Stage 1:** (2 days minimum) Light activity (walking, jogging, and stationary bike) for 15 minutes or less at an intensity no greater than 70% of maximum heart rate. NO resistance training.

   b. **Stage 2:** (1 day minimum) Add simple movement activities (running drills) for 30 minutes or less at intensity no greater than 80% of maximum heart rate.

   c. **Stage 3:** (1 day minimum) Progress to more complex training for 45 minutes or less at intensity no greater than 80% of maximum heart rate. May add light resistance training.

   d. **Stage 4:** (2 days minimum) Normal training activity for 60 minutes or less at an intensity no greater than 80% of maximum heart rate.

   e. **Stage 5:** Return to full activity after the school nurse and/or athletic trainer has certified completion of this full Return to Activity Protocol.

4. If there are any symptoms that develop along the Return to Activity Protocol process, we will refer the student back to their physician for further evaluation.
Medical Authorization to Return to Activity
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 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. **Hawken is extending this to include all students involved with physical activity on campus.** 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 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 activities. To reiterate, this student is not permitted to re-enter activity until they are cleared by a physician or licensed medical provider and have completed the return to activity progression.

I have examined ______________________________ and determined that he/she is:

___ Cleared to return to participation after completing return to activity protocol listed on other side
___ Not Cleared and Referred to a cardiologist or other specialist
___ Return to activity clearance is limited to the following ______________________________

**Signature of Medical Professional:**

______________________________________________________________________________

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

**Date:** ________________________________

**Phone:** ________________________________

**Address:** __________________________________

(Print or stamp address)