Manhattan Soccer Club Return to Play Following Illness Form

Date: _____

Player/Staff Name:_____

Player/Staff Team: _____

Player/Staff Date of Birth: _____
The player/staff member has experienced the following symptoms that have been associated with COVID-19:
__ Fever (Temperature greater than or equal to 100 degrees F)
__Cough
__Shortness of Breath/Difficulty Breathing
__Congestion/Runny Nose
__Fatigue/Tiredness
__Sore Throat
__Headache
__Loss of Sense of taste or smell
__Nausea or Vomiting
__Diarrhea
__Stomache Ache
__Muscle Weakness/Body aches
__Rash
__Night Sweats
__Chills
__Other:

Returning to Manhattan SC Activities after illness:
If a player/staff member has symptoms of COVID-19, including any of the symptoms above, and does not see a doctor, then he/she may not participate in in-person MSC activities until it has been at least 10 days from symptom onset, with the last 3 days (72 hrs) fever-free without the use of fever-reducing medications and an overall reduction in symptoms.

If a player/staff member has symptoms of COVID-19, including any of the symptoms above, and DOES see a doctor, he/she must meet all of the criteria in one box to return to MSC in-person activities. (Please ask the physician to fill out all items in one of these boxes):

__ I HAVE EXAMINED THE ABOVE PATIENT, WHO PRESENTED WITH SYMPTOMS OF POSSIBLE COVID-19, BUT I HAVE DETERMINED THAT COVID-19 IS NOT SUSPECTED
__Negative COVID-19 rt-PCR test (please attach result) OR __It has been at least 10 days since the onset of symptoms and symptoms have resolved (including no fever, without the use of fever-reducing medications) for at least 24 hrs. OR __Patient has a different diagnosis (ie

strep, flu), supported by laboratory testing that is the cause of their symptoms (please attach test result)
__The patient is no longer expected to be contagious and may return to in-person activities on __/__/__
Medical Provider Name:_____
Medical Provider Signature: _____
Date: _____
Office Phone Number: _____
License #/NPI #: _____

__I HAVE EXAMINED THE ABOVE PATIENT AND DIAGNOSED THIS PATIENT WITH COVID-19 BASED ON A POSITIVE LABORATORY TEST (please attach result) AND/OR HIGH CLINICAL SUSPICION FOR COVID-19
__Documentation of release from isolation as required by the Department of Health, clearance note to return to school from healthcare provider and
__It has been at least 10 days since the student first had symptoms; AND Symptom resolution (including no fever, without the use of fever-reducing medications for at least 24 hrs)
__The patient may return to in-person activities on __/__/__.
Medical Provider Name:_____
Medical Provider Signature: _____
Date: _____
Office Phone Number: _____
License #/NPI #: _____