

SOUTH AMBOY ATHLETICS

COVID-19 Physician Evaluation Form

Dear Physician:

Date: _____

_____ has been removed from participating in _____ practices/workouts for a South Amboy athletic team for the reason checked below:

_____ Has been diagnosed with COVID-19 or has tested positive for COVID-19 virus and/or antibodies

_____ A member of their household has been diagnosed with COVID-19

_____ Indicated the following pre-existing medical condition on their questionnaire: _____

In accordance with the COVID-19 procedures of the South Amboy school district, and at the direction of the South Amboy school physician, the student-athlete must be evaluated and cleared by their physician before they can resume activity.

Please evaluate this student-athlete and indicate your directives in the box below. If you have any questions, please feel free to contact us.

Mr. Frank Zalocki, VP/AD
fzalocki@sapublicschools.com

For the Physician: Please complete the section below.

Patient Name: _____

Date: _____

Please check ONE:

_____ The patient may resume participation in South Amboy athletics with no restrictions, as of: ___/___/___

_____ The patient may not participate in South Amboy athletics at this time and will return for re-evaluation and/or be referred for further examination

_____ I have additional directives beyond the above recommendations (please specify): _____

Physician's name (print): _____

Phone: _____

Physician's Signature: _____

Physician/Provider's Stamp