INTEROFFICE CORRESPONDENCE
Los Angeles Unified School District
Division of Instruction
Division of Student Health and Human Services

TO: Local District Superintendents
Administrators of Operations
Community of School Administrators
All Secondary School Principals
Assistant Principals, Athletics
Athletic Directors
District Nursing Administrators
School Nurses

Date: July 6, 2021
REVISED Date: August 6, 2021

FROM: Trenton Cornelius, Coordinator
Interscholastic Athletic Department

Sosse Bedrossian, Director,
District Nursing Services

SUBJECT: NEW PRE-PARTICIPATION PHYSICAL EXAMINATION FORM REQUIRED FOR PHYSICAL EXAMS CONDUCTED ON OR AFTER AUGUST 23, 2021 & POST-COVID MEDICAL CLEARANCE PROCEDURES

The purpose of this interoffice correspondence is to provide a **revised Pre-Participation Physical Examination form**, which will be **required for all examinations conducted on or after August *23*, 2021**, until further notice. This new form includes questions regarding known exposure to and/or a positive COVID-19 test. Attached are copies of the new form in English and Spanish.

For students who are returning to play after a positive COVID-19 test, please also see the **COVID – 19 Return to School and Clearance to Begin COVID Graduated Return to Play (GRTP) and the COVID Graduated Return to Play (GRTP) forms**, attached.

School sites must share the new Pre-Participation Physical Examination form and communicate this requirement with all student-athletes. Forms can be found on the L.A. Unified Interscholastic Athletic Department webpage. Schools are also able to make these forms available on their school athletics webpage.

All athletes will be required to use the revised Pre-Participation Physical Examination form with their health provider beginning August 23, 2021. Athletes who submit the old form for any exam conducted after August 22, 2021, will be required to return to their health care provider in order to complete this new version of the form.

Once Pre-Participation Physical Examinations (physicals) are collected, only athletic directors will contact their local district nursing administrator(s) and arrange for clearance of the physicals.

Local District Nursing Services:

- Central Nursing Specialist:
  Clare Reid, Phone: (213) 766-7308 E-mail: clare.reid@lausd.net
  Pilar Llanes, Phone: (213) 766-7308 E-mail: pilar.llanes@lausd.net

- East Nursing Coordinator:
  Grace Guillen, Phone: (323) 224-3325 E-mail: grace.guillen@lausd.net

- Northeast Nursing Coordinator:
  Cheryl Davison, Phone: (818) 686-4460 Email: cad0840@lausd.net

- Northwest Nursing Coordinator:
  Eileen Mitchell, Phone: (818) 654-1670 E-mail: eileen.mitchell@lausd.net

- South Nursing Coordinator:
  Allison Barancho, Phone: (310) 354-3550 E-mail: allison.barancho@lausd.net

- West Nursing Coordinator:
  Andrea Coleman, Phone: (310) 235-3770 Email: andrea.coleman@lausd.net

All athletes must be cleared prior to any tryouts in order to avoid delays. Athletic directors will review all physicals for commonly encountered errors. Athletic directors will ensure all physicals meet the following requirements:

- Correct version of physical form is used (See BUL-4948.2 – *Medical Clearance and Return to Play Guidelines for Students Participating in Interscholastic Athletics and Select Auxiliary* Units, dated January 4, 2016, for exams conducted prior to August 22, 2021; **attached version shall be used for all exams conducted on or after August *2*3, 2021, until further notice**.
- All fields on both pages have been completed
- All items checked "yes" have a corresponding explanation
- Completed by a qualified California licensed medical professional, as noted below:
  - Medical Doctor (MD)
  - Doctor of Osteopathic Medicine (DO)
  - Nurse Practitioner (NP) or
  - Physician's Assistant (PA)
- Health care provider information (address, phone number, and signature) and stamp is included
- Physical was done within the last 12 months and includes vision screening results, blood pressure, and pulse.

Once the physicals have undergone the above review process, the athletic director will provide a copy of the roster of students and the physicals alphabetized by sport. Once a minimum of 30 fully screened and completed physicals have been completed, the athletic director will contact the corresponding nursing administrator(s) to arrange

clearance. After the initial 30 physicals have been submitted, Local District nursing administrator(s) will work with school sites to clear physicals totaling less than 30.

School nurses available to clear physicals should contact their Local District nursing administrator for their assigned schools and available hours for clearances. All funding will be allocated centrally to Nursing Services and funds will be made available to identified school nurses clearing physicals. These additional hours must receive prior approval by the nursing administrator in order to be paid.

Should you have questions or would like additional information, please contact the athletic director, the Interscholastic Athletic Department via e-mail at interscholasticathletics@lausd.net, the school nurse, or District Nursing Services.

Attachment A: Pre-Participation Physical Evaluation (English)
Attachment A1: Pre-Participation Physical Evaluation (Spanish)
Attachment B: Student Health and Human Services Parent Letter Regarding Sports (English and Spanish)
Attachment C: Guidance for the School Nurse when Screening Pre-Participation Examination (PPE) Forms as of 8/23/21
Attachment D: COVID – 19 Return to School and Clearance to Begin COVID Graduated Return to Play (GRTP)

C: Alison Yoshimoto-Towery
Pia Escudero
Alicia Guarupa
Christina Rico

Los Angeles Unified School District
Pre-Participation Physical Evaluation

Date of Exam:_____

ATTACHMENT A

Student's Name:_____ Sex:_____ Age:_____ Date of Birth:_____ Grade:_____
School:_____ Sport(s):_____
Address:_____ Phone:_____
Personal Physician/Provider: _____
In case of emergency, contact: Name:_____ Relationship:_____
Telephone: (Home)_____ (Work)_____ (Cell)_____ (Cell) _____

Medicines and Allergies: Please list all the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging insects

This section is to be carefully completed by the student and his/ her parent(s) or legal guardian(s) before participation in interscholastic athletics. ***Explain Yes answers below. Circle questions you don't know the answers to.***

	GENERAL QUESTIONS	Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?		
2.	Do you have any ongoing medical conditions? If so, please identify below: ☐Asthma ☐Anemia ☐Diabetes ☐Infections Other:_____		
3.	Have you ever spent the night in a hospital?		
4.	Have you ever had surgery?		
	HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5.	Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7.	Does your heart ever race or skip beats (irregular beats) during exercise?		
8.	Has a doctor ever told you that you have any heart problems? If so, check all that apply:		
	☐ Kawasaki disease ☐ A Heart Infection ☐ High Blood Pressure ☐ A Heart Murmur ☐ High Cholesterol Other:_____		
9.	In the last 14 days, have you been exposed to someone who tested positive for COVID-19?		
10	Have you ever tested positive for COVID-19 virus? Date of (+) COVID-19 Test: _____		
11.	Has a doctor ever ordered a test for your heart (for example, ECG/EKG, echocardiogram)?		
12.	Do you get lightheaded or feel more short of breath than expected during exercise?		
13.	Have you ever had an unexplained seizure?		
14.	Do you get more tired or short of breath more quickly than your friends during exercise?		
	HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
15.	Has any family member or relative died of heart problems or had an unexpected		
16.	Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
17.	Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
18.	Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
	BONE AND JOINT QUESTIONS	**Yes**	**No**
19.	Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendinitis that caused you to miss a practice or game?		
20.	Have you had any broken or fractured bones or dislocated joints?		
21.	Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
22.	Have you ever had a stress fracture?		
23.	Have you been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
24.	Do you regularly use a brace, orthotics or other assistive device?		
25.	Do you have a bone, muscle or joint injury that bothers you?		
26.	Do any of your joints become painful, swollen, feel warm, or look red?		
27.	Do you have any history of juvenile arthritis or connective tissue disease?		

	MEDICAL QUESTIONS	Yes	No
28.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
29.	Have you ever used an inhaler or taken asthma medicine?		
30.	Is there anyone in your family who has asthma?		
31.	Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
32.	Do you have groin pain or a painful bulge or hernia in the groin area?		
33.	Have you had infectious mononucleosis (mono) within the last month?		
34.	Do you have any rashes, pressure sores, or other skin problems?		
35.	Have you had a herpes or MRSA skin infection?		
36.	Have you ever had a head injury or concussion?		
37.	Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
38.	Do you have a history of seizure disorder?		
39.	Do you have headaches with exercise?		
40.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
41.	Have you ever been unable to move your arms or legs after being hit or falling?		
42.	Have you ever become ill while exercising in the heat?		
43.	Do you get frequent muscle cramps when exercising?		
44.	Do you or someone in your family have sickle cell trait or disease?		
45.	Have you had any problems with your eyes or vision?		
46.	Have you had any eye injuries?		
47.	Do you wear glasses or contact lenses?		
48.	Do you wear protective eyewear, such as goggles or a face shield?		
49.	Do you worry about your weight?		
50	Are you trying to or has anyone recommended that you gain or lose weight?		
51.	Are you on a special diet or do you avoid certain types of food?		
52.	Have you ever had an eating disorder?		
53.	Do you have any concerns that you would like to discuss with a doctor?		
	FEMALES ONLY		
54.	Have you ever had a menstrual period?		
55.	How old were you when you had your first menstrual period?		
56.	How many periods have you had in the last 12 months?		
	Explain "yes" answers here:		

I hereby state, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete_____ Signature of parent/guardian_____ Date_____

Los Angeles Unified School District
Pre-Participation Physical Evaluation

Physical Examination Form

The section below is to be completed by physician or staff after history and consent forms are completed.

ATTACHMENT A

Student's Name: _____ DOB: _____

Height: _____ Weight: _____ %BMI (optional): _____ Pulse: _____ BP: _____/_____, (_____/_____, _____/_____)

Vision: R 20/_____ L 20/_____ Corrected: ☐ Y ☐ N Pupils: Equal _____ Unequal _____

EMERGENCY INFORMATION

Allergies: _____

Other Information: _____

MEDICAL	Normal	Abnormal Findings
Appearance • Marfan stigmata (kyphoscoliosis, high arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ Ears/ Nose/ Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart [1] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Lungs		
Abdomen		
Genitourinary (males only) [2]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [3]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/ Arm		
Elbow/ Forearm		
Wrist/ Hand/ Fingers		
Hip/ Thigh		
Knee		
Leg/ Ankle		
Foot/ Toes		
Functional • Duck walk, single leg hop		

[1] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam
[2] Consider GU exam if in private setting. Having 3rd party present is recommended.
[3] Consider cognitive evaluation or baseline neuropsychiatric setting if a history of significant concussion.

Clearance

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for: _____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports: _____

Reason/Recommendations: _____

I have evaluated the above named student and completed the pre-participation physical evaluation. The athlete does not present apparent contraindications to practice, tryout and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parent. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician/ Provider: (print/ type/ stamp) _____ (MD, DO, NP or PA) Date: _____

Address: _____ Phone: _____

Signature of Physician/ Provider: _____

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2010.

Distrito Escolar Unificado de Los Ángeles

Fecha del exámen:_____ ANEXO A-1

Nombre del alumno(a):_____ Sexo:_____ Edad:_____ Fecha de nacimiento: _____
Grado:_____ Escuela:_____ Deporte(s): _____
Dirección:_____ Teléfono:_____
Doctor o proveedor médico personal:
Persona a notificar en caso de emergencia. Nombre:_____ Relación:_____
Teléfono: (Casa)_____ (Trabajo)_____ (Celular)_____ (Celular)

Medicamentos y alergias: Por favor enumere todas las medicinas y suplementos (naturales y nutritivos) con o sin receta médica que actualmente toma.

¿Padece de alguna alergia? ☐ Yes ☐No Si marcó 'Sí', por favor identifique la alergia específica a continuación.

☐ Medicamentos ☐Polen ☐Alimentos ☐Picaduras de insectos

El padre/madre/tutor legal y el alumno(a) deben cuidadosamente completar esta sección antes de participar en el programa deportivo interescolar. ***Explique las respuestas con "Sí" a continuación. Marque con un circulo las preguntas que no sepa.***

PREGUNTAS GENERALES	Sí	No
1. ¿Alguna vez le ha negado un doctor la participación en los deportes por alguna razón?		
2. ¿Padece constantemente de alguna afección médica? Si respondió 'Sí', por favor identifíquela a continuación: ☐Asma ☐Anemia ☐Diabetes ☐ Infecciones Otra:_____		
3. ¿Alguna vez pasó la noche hospitalizado?		
4. ¿Alguna vez tuvo alguna cirugía?		
PREGUNTAS SOBRE SU SALUD CARDÍACA	**Sí**	**No**
5. ¿Alguna vez se ha desmayado o ha estado a punto de desmayarse DURANTE o DESPUÉS de hacer ejercicio?		
6. ¿Ha sentido alguna vez incomodidad, dolor, tensión o presión en el pecho durante el ejercicio?		
7. ¿Su corazón a veces se acelera o late irregularmente durante el ejercicio?		
8. ¿Alguna vez le ha dicho un doctor que padece de problemas cardiacos? Si respondió 'Sí', marque lo que corresponda: ☐ Enfermedad de Kawasaki ☐ Una infección cardíaca ☐ Presión alta ☐ Un soplo cardíaco ☐ Colesterol alto Otro: _____		
9. ¿En los últimos 14 días ha estado expuesto a alguien que dio positivo a una prueba del virus COVID-19?		
10. ¿Alguna vez ha dado positivo a una prueba del virus COVID-19? Fecha de la prueba (+) COVID-19:_____		
11. ¿Alguna vez le ordenó el doctor una prueba del corazón (por ejemplo un electrocardiograma o ecocardiograma)?		
12. ¿Se marea o le falta el aire más de lo esperado durante el ejercicio?		
13. ¿Ha tenido alguna vez algún ataque inexplicado?		
14. ¿Se cansa o le falta el aire más rápidamente que a sus amigos durante el ejercicio?		
PREGUNTAS DE LA SALUD DE SU FAMILIA	**Sí**	**No**
15. ¿Ha habido alguna muerte por problemas cardíacos o una muerte repentina e inesperada o inexplicable antes de los 50 años de algún miembro de su familia o pariente (incluyen ahogados, accidente automovilístico inexplicado, o síndrome de muerte infantil súbita?		
16. ¿Alguien de su familia padece de cardiomiopatía hipertrópica, síndrome de Marfan, cardiomiopatía arritmogénica del ventrículo derecho, síndrome de QT largo o corto síndrome de Brugada o taquicardia catecolaminérgica polymórfica ventricular?		
17. ¿Alguien de su familia padece de problemas cardíacos, tiene un marcapasos o desfibrilador implantado?		
18. ¿Alguien de su familia se ha desmayado o ha tenido algun ataque inexplicable o ha estado a punto de ahogarse?		
PREGUNTAS SOBRE LOS HUESOS Y LAS ARTICULACIONES	**Sí**	**No**
19. ¿Ha tenido alguna lesión, tal como una torcedura, un desgarre múscular o de un ligamento, o tendonitis, que le haya hecho faltar a la práctica o a algún juego?		
20. ¿Se ha roto o fracturado algún hueso o se ha dislocado alguna articulación?		
21. ¿Ha tenido alguna lesión que haya requerido Rayos-X, MRI, CT escanear, una terapia, inyecciones, un aparato ortopédico, enyesado o muletas?		
22. ¿Alguna vez ha tenido una fractura por estrés?		
23. ¿Le han dicho alguna vez que se haga o se ha hecho una radiografía para la inestabilidad atlantoaxial o del cuello? (Síndrome de Down o enanismo)		
24. ¿Usa regularmente algún aparato ortopédico, ortótico o de asistencia?		
25. ¿Tiene alguna lesión del hueso, músculo o articulación que le moleste?		

PREGUNTAS SOBRE LOS HUESOS Y LAS ARTICULACIONES	Sí	No
26. ¿Alguna articulación le duele, se hincha, se siente tibia o se ve rojiza?		
27. ¿Tiene un historial de artritis juvenil o enfermedad del tejido conectivo?		
PREGUNTAS MÉDICAS		
28. ¿Tose, resolla o respira con dificultad durante o después de hacer ejercicio?		
29. ¿Ha usado alguna vez un inhalante o tomado medicina para el asma?		
30. ¿Alguien de su familia padece de asma?		
31. ¿Nació sin un riñón o le falta un riñón, un ojo, un testículo (hombres), el bazo o cualquier otro órgano?		
32. ¿Tiene dolor en la ingle o un bulto o hernia dolorosa en el area de la ingle?		
33. ¿Ha padecido de mononucleosis (mono) infecciosa en el último mes?		
34. ¿Tiene alguna erupción cutánea, llagas por presión u otro problema de la piel?		
35. ¿Ha tenido una infección por herpes o de MRSA?		
36. ¿Ha tenido alguna lesión en la cabeza o concusión cerebral?		
37. ¿Ha te nido algún golpe o impacto a la cabeza que le causó confusión, dolor de cabeza prolongado o problemas de la memoria?		
38. ¿Tiene un historial de trastorno convulsivo?		
39. ¿Le duele la cabeza cuando hace ejercicio?		
40. ¿Alguna vez ha sentido adormecimiento, hormigueo o debilidad en los brazos o piernas después de caerse o ser golpeado(a)?		
41. ¿Alguna vez no ha podido mover los brazos o las piernas luego de caerse o ser golpeado(a)?		
42. ¿Alguna vez se ha sentido enfermo mientras hacía ejercicio en el calor?		
43 ¿Tiene calambres musculares frecuentes al hacer ejercicio?		
44. ¿Usted o alguien de su familia tiene razgos de o padece de anemia drepanocítica?		
45. ¿Ha tenido problemas de los ojos o la visión?		
46. ¿Ha sufrido alguna lesión de los ojos?		
47. ¿Usa anteojos o lentes de contacto?		
48. ¿Usa lentes de protección, tales como gafas protectoras o protector facial?		
49. ¿Le preocupa su peso?		
50. ¿Está tratando de bajar o subir de peso, o alguien le ha recomendado que gane o pierda peso?		
51. ¿Está en una dieta especial o evita ciertos tipos de comida?		
52. ¿Ha padecido alguna vez de un trastorno alimenticio?		
53. ¿Tiene alguna inquietud que le gustaría tratar con un doctor?		
PARA MUJERES SOLAMENTE		
54. ¿Ha tenido alguna vez un período menstrual?		
55. ¿A qué edad tuvo su primer período menstrual?		
56. ¿Cuántos periodos ha tenido en los últimos 12 meses?		
Explique las respuestas de "Si." Aqui:		

Por la presente indico que, a mi leal saber y entender, mis respuestas anteriores estan completas y correctas.

Firma del atleta_____ Firma delpadre/madre/tutor legal_____ Fecha _____

Physical Examination Form

The section below is to be completed by physician or staff after history and consent forms are completed.

ANEXO A-1

Student's Name:_____ DOB: _____

Height:_____ Weight:_____ %BMI (optional):_____ Pulse:_____ BP:_____/_____, (_____/_____, _____/_____)

Vision: R 20/_____ L 20/_____ Corrected: ☐ Y ☐ N Pupils: Equal_____ Unequal _____

EMERGENCY INFORMATION

Allergies: _____

Other Information: _____

MEDICAL	Normal	Abnormal Findings
Appearance • Marfan stigmata (kyphoscoliosis, high arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ Ears/ Nose/ Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart [1] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Lungs		
Abdomen		
Genitourinary (males only) [2]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [3]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/ Arm		
Elbow/ Forearm		
Wrist/ Hand/ Fingers		
Hip/ Thigh		
Knee		
Leg/ Ankle		
Foot/ Toes		
Functional • Duck walk, single leg hop		

[1] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam

[2] Consider GU exam if in private setting. Having 3rd party present is recommended.

[3] Consider cognitive evaluation or baseline neuropsychiatric setting if a history of significant concussion.

Clearance

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for: _____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports: _____

Reason/Recommendations: _____

I have evaluated the above -named student and completed the Pre-Participation Physical Evaluation. The athlete does not present apparent contraindications to practice, tryout and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parent. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician/ Provider: (print/ type/ stamp)_____ (MD, DO, NP or PA) Date: _____

Address:_____ Phone: _____

Signature of Physician/ Provider: _____

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2010.

LOS ANGELES UNIFIED SCHOOL DISTRICT
STUDENT HEALTH AND HUMAN SERVICES

Student Health & Human Services

Dear LAUSD athletes and their parents/guardians:

COVID-19 and its wide range of complications may present challenges to everyday activities. **One of the complications affecting sports participation is damage to the heart**. The greater the severity of COVID-19, the greater the risk is for heart disease. Please speak to your health care provider regarding sports participation after a positive test for COVID-19 within the last 3-6 months or if at any time you have symptoms consistent with COVID-19 (fever/chills, cough, shortness of breath or difficulty breathing, muscle or body aches, headache, new lost sense of taste or smell, sore throat, nasal congestion, nausea, vomiting, and/or diarrhea). Your health care provider should include screening questions for cardiac symptoms such as palpitations, irregular pulse, chest pain, difficulty breathing, fainting, and fatigue, and complete the medical clearance form, "COVID-19 Return to School and Clearance to Begin COVID Graduated Return to Play (GRTP)."*

Asymptomatic disease (no COVID-19 symptoms)

- **Medical clearance after testing positive for COVID-19 within the last 3 months**
- **Medical clearance not required if at full activity after testing positive for COVID-19 after 3 months**

Mild disease (fever < 4 days, other symptoms < 1 week except for loss of smell/taste and cough)

- **Medical evaluation (interview and physical exam) and medical clearance after testing positive COVID-19 within the last 3 months**
- **Medical evaluation and medical clearance not required if at full activity after testing positive COVID-19 after 3 months**

Moderate disease (fever ≥ 4 days, other symptoms ≥ 1 week except for loss of smell/taste and cough)

- **Medical evaluation (interview, physical exam and EKG) and medical clearance after testing positive for COVID-19 within the last 6 months**
- **Medical evaluation and medical clearance not required if at full activity after testing positive for COVID-19 after 6 months**

Severe disease (overnight hospitalization, multi-inflammatory syndrome in children [MIS-C])

- **No sports participation for 3-6 months**
- **Medical evaluation (interview, physical exam and screening tests for heart disease) and medical clearance after testing positive for COVID-19 within the last 6 months**
- **Medical clearance to continue current level of activity after testing positive for COVID-19 after 6 months**

Consultation with your health care provider regarding COVID-19 and sports participation is highly advised when medical clearance/evaluation is not required.

Not required if no history of positive test result for COVID-19.

LOS ANGELES UNIFIED SCHOOL DISTRICT
STUDENT HEALTH AND HUMAN SERVICES

Student Health & Human Services

Estimados atletas del LAUSD y sus padres/tutores:

La COVID-19 y su amplia gama de complicaciones pueden presentar problemas en las actividades cotidianas. **Una de las complicaciones que afectan a la participación en los deportes es el daño al corazón.** Cuanto mayor sea la gravedad del COVID-19, mayor será el riesgo de sufrir una enfermedad cardíaca. Por favor, hable con su proveedor de atención médica con respecto a la participación en deportes después de una prueba positiva de COVID-19 en los últimos 3-6 meses, o si en cualquier momento se presentan síntomas compatibles con COVID-19 (fiebre/escalofríos, tos, falta de aliento o dificultad para respirar, dolores musculares o corporales, dolor de cabeza, nueva pérdida del sentido del gusto o del olfato, dolor de garganta, congestión nasal, náuseas, vómitos y/o diarrea). Su proveedor de atención médica debería incluir las preguntas de detección de síntomas cardíacos como palpitaciones, pulso irregular, dolor en el pecho, dificultad para respirar, desmayos y fatiga, y debería completar el formulario de autorización médica, "Regreso a la escuela después de COVID-19 y Autorización para comenzar el regreso gradual al juego después de COVID (GRTP)". *****

Enfermedad asintomática (sin síntomas de COVID-19)

- **Autorización médica tras haber dado positivo en la prueba de COVID-19 en los últimos 3 meses**
- **No se requiere autorización médica si está en plena actividad después de dar positivo en COVID-19 después de 3 meses**

Enfermedad leve (fiebre < 4 días, otros síntomas < 1 semana excepto la pérdida de olor/sabor y tos)

- **Evaluación médica (entrevista y examen físico) y autorización médica tras dar positivo en la prueba COVID-19 en los últimos 3 meses**
- **Evaluación y autorización médica no requeridas si se encuentra en plena actividad después de dar positivo en COVID-19 después de 3 meses**

Enfermedad moderada (fiebre ≥ 4 días, otros síntomas ≥ 1 semana excepto la pérdida de olor/sabor y tos)

- **Evaluación médica (entrevista, examen físico y electrocardiograma) y autorización médica tras dar positivo en la prueba COVID-19 en los últimos 6 meses**
- **Evaluación y autorización médica no requeridas si se encuentra en plena actividad después de dar positivo en COVID-19 después de 6 meses**

Enfermedad grave (hospitalización de una noche, síndrome de inflamación múltiple infantil [MIS-C])

- **No participará en deportes durante 3-6 meses**
- **Evaluación médica (entrevista, examen físico y pruebas de sondeo de la enfermedad al corazón) y autorización médica tras dar positivo en la prueba COVID-19 en los últimos 6 meses**
- **Autorización médica para continuar en nivel de actividad actual después de dar positivo de COVID-19 después de 6 meses**

Es muy aconsejable que consulte con su médico en relación con COVID-19 y la participación en deportes cuando la autorización/evaluación médica no es requerida.

No es necesario si no hay antecedentes de resultados positivos en las pruebas de COVID-19.

3 de mayo de 2021

Guidance for the School Nurse when Screening Pre-Participation Examination (PPE) Forms as of 8/23/21

Refer to IOC: NEW PRE-PARTICIPATION PHYSICAL EXAMINATION FORM REQUIRED FOR PHYSICAL EXAMS CONDUCTED ON OR AFTER AUGUST 23, 2021.

This guidance is being provided to assist the school nurse who will be screening PPE forms regarding responses to updated COVID-19 related questions on the health history. It should **not** be disseminated to parents, students, or other school personnel and is not intended to replace professional judgment. If additional clarification is required, the school nurse should consult with their school nurse administrator, school doctor, or the student's healthcare provider when necessary. **Public health guidance may result in changes to this document-refer to reference links below***

9	In the last 14 days, have you been exposed to someone who tested positive for COVID-19?
10	Have you ever tested positive for COVID-19 virus? Date of (+) COVID-19 Test: _____

#9: A "yes" response must have an additional explanation written on the form provided by the parent. Clearance of the physical and follow up should be based upon current District guidelines and state and LACDPH protocols regarding quarantine and isolation.

#10: A "yes" response must include the date of the positive test and an explanation written on the form provided by the parent. Date of healthcare provider clearance must reflect that the PPE was completed after testing positive for COVID-19. The explanation should describe the type of disease symptoms they experienced:

Positive Covid test (within last 3 months) and Asymptomatic disease (no COVID-19 symptoms) **or with report of mild disease** (fever < 4 days, other symptoms < 1 week except for loss of smell/taste and cough). This PPE as it relates to COVID-19 requires no additional information to continue with screening.

Positive Covid test with Moderate disease (fever > 4 days, other symptoms > 1 week except for loss of smell/taste and cough)

- Positive within the last 6 months: PPE to **include EKG** with results interpreted and cleared by health care provider.
- Positive more than 6 months ago if at full activity now. This PPE as it relates to COVID-19 requires no additional information to continue with screening.

Severe disease (overnight hospitalization, multi-inflammatory syndrome in children [MIS-C])

- **No sports participation for 3-6 months after positive COVID-19 test.**
- Positive within the last 6 months: PPE to include EKG and screening tests for heart disease with results interpreted and cleared by healthcare provider.
- Positive more than 6 months ago. Healthcare provider should include documentation related to severe disease and confirm student is medically cleared to continue current level of activity after testing positive for COVID-19 after 6 months.

*It is suggested to keep the keep the following links available for reference related to updates in public health guidance:

(LACDPH) Reopening Protocols for K-12 Schools: Appendix T1
http://publichealth.lacounty.gov/media/Coronavirus/docs/protocols/Reopening_K12Schools.pdf

(LACDPH) COVID-19 Exposure Management Plan Guidance Youth Recreational Sports Programs
http://publichealth.lacounty.gov/media/coronavirus/docs/protocols/ExposureManagementPlan_YouthSports.pdf

Los Angeles Unified School District
Student Health and Human Services

COVID – 19 Return to School and Clearance to Begin COVID Graduated Return to Play (GRTP)
To be completed by a Health Care Provider (MD/DO/NP/PA)

Student Name_____Date of Birth_____Grade_____Sport _____

Date of Positive COVID-19 Test_____Type of Test _____

Date of Negative Test and/or Symptom Resolution _____

Severity of Symptoms (choose one) ☐ No Symptoms ☐Mild Illness

☐ Moderate Illness ☐ Severe Illness

Diagnostics Performed and Results: _____

_____

☐ Completed GRTP, No Restrictions ☐Cleared to begin GRTP ☐Pending_____☐Not Cleared _____

Health Care Provider Notes/Recommendations_____

_____

CA Licensed Health Care Provider (Stamp) _____

Signature of CA Licensed Health Care Provider _____

Address:_____Telephone No._____Date_____

Clearance by a cardiologist is MANDATORY when a Cardiology referral is given.

Los Angeles Unified School District
COVID Graduated Return to Play (GRTP)

Instructions:

- This recommended CIF GRTP Protocol should be completed before returning to FULL COMPETITION no earlier than day 8.
- An adult (e.g. parent) or school personnel (e.g., certified athletic trainer, AD, coach) should monitor you during this protocol.
- This protocol can take longer than 7 days if instructed by your physician/healthcare provider.
- The symptom-free period (part of the Rest Period) can also take longer than 7 days depending on the severity of your illness.
- If symptoms return at any time in this progression, IMMEDIATELY STOP any physical activity and follow up with your physician/healthcare provider. You will need to be cleared by your healthcare provider to return to the GRTP Protocol.
- Symptoms can include chest pain, chest tightness, palpitations, lightheadedness, feeling faint or fainting, shortness of breath, fatigue
- Seek medical attention if you feel uncomfortable at any time during the progression.

Athlete's Name:_____ Date of + COVID Test:_____ Symptoms? No Yes: Date of Symptom Onset _____

GRTP Monitor (Print Name)_____ Position_____ Signature _____

Date & Initials	Days	Activity Description	Exercise Allowed	Objective of the Stage
TO BE COMPLETED BEFORE RETURNING TO SCHOOL	**Minimum 10 days**	***Rest Period:*** Limited physical activity for: --10 days from asymptomatic (+) test *OR* --10 days from onset of symptoms *with at least 7 days with no symptoms (exception is loss of taste and smell)*	• Activities of daily living (ADLs), walking okay • No activities requiring any exertion (weightlifting, jogging, P.E. classes)	• Recovery and/or reduction/elimination of symptoms to protect the cardiorespiratory system
Before starting, must be able to complete ADLs and walk ~1/4th mile without fatigue or breathlessness				
	1	Light aerobic activity	• 10-15 minutes *(min)* of brisk walking or light stationary biking, light elliptical • No resistance training	• Increase heart rate to ≤ 50% of perceived maximum *(max)* exertion (e.g.,< 100 beats per min) • Monitor for symptom return
	2	Light aerobic activity	• 15-20 min of brisk walking or light stationary biking, light elliptical • No resistance training	• Increase load gradually • Increase heart rate to 50% max exertion (e.g.,100 bpm) • Monitor for symptom return
Nurse Verification of Physician Clearance		**NAME (please print)**	**SIGNATURE**	**DATE**
	3	Moderate aerobic activity Light resistance training	• 20-30 min jogging, light biking, swimming • Body weight exercises (squats, planks, push- ups), max 1 set of 10, ≤ 10 min total	• Increase load gradually • Increase heart rate to 50-75% max exertion (e.g.,100-150 bpm) • Monitor for symptom return
	4	Strenuous aerobic activity Moderate resistance training	• 30-45 min running, biking, swimming • Weightlifting ≤ 50% of max weight	• Increase load gradually • Increase heart rate to > 75% max exertion • Monitor for symptom return
	5	Non-contact training with sport-specific drills No restrictions for weightlifting	• 45-60 min of non-contact drills, sport-specific activities (cutting, jumping, sprinting)	• Coordination and skills/tactics • Acceleration/deceleration with total body movement • Monitor for symptom return
	6	Limited practice including limited contact	• Controlled drills including contact drills (but no scrimmaging)	• Restore confidence and assess functional skills • Assess readiness for return to play • Increase acceleration, deceleration, and rotational forces • Monitor for symptom return
	7	Full unrestricted practice	• Return to normal unrestricted training (with contact)	
	8	Return to play (competition)	• Normal game play (competitive event)	• Return to full sports activity without restrictions