Goal

- To assist team physicians in helping athletes return to training as phased return as “stay at home” guidelines are relaxed once the apex of the infectious curve has been reached and begins to decline in their particular geographic location.
- To give reassurance to team management, staff, coaches, athletes and parents that athletes under certain conditions may safely train/participate in sport as a team.

Summary

This document provides a current guideline for COVID-19 management for team physicians with the understanding that it must be fluid as more is learned about this novel virus. It should not be looked at as a practice or standard-of-care document and should not be used in such a manner, but attempts to create a framework for return to training based on current knowledge about COVID-19. This document explores certain scenarios of medical symptoms and management guidelines. This statement was developed by a group of multi-discipline specialists, including Family Medicine, Internal Medicine, Infectious Disease, and Certified Athletic Training, to help guide team physicians on the management of athletes engaged in phased return from “stay at home” guidelines.

The various phased openings provided by the CDC, NCAA, and USOPC were reviewed during the writing of this document and are referenced at the end of this document. These guidelines are an attempt to provide specific steps to consider once Phase 3 of NCAA opening or Phase 4 of the USOPC opening concerning group training has been achieved.

Introduction

It is essential that team physicians begin to establish Return-to-Training guidelines for the athlete during the COVID-19 pandemic. It is understood that these guidelines will be fluid and need to be updated as more data emerges concerning incubation, infectivity, infection length, recovery, and establishment of immunity concerning this novel virus. Athletes and teams affected by COVID-19 need to have individualized return-to-training guidelines because of the variable outcome of the course of the disease and lack of evidence-based information concerning this novel virus.

Recommended equipment for the medical staff, ATC, and individual athletes as discussed in the guidelines

1. Head scan thermometer is preferred. Single-use thermometer or multi-use thermometer with a protective cover is acceptable.

   A. Necessity would be to check oral or forehead/temporal temperature once in AM and once in PM OR if the athlete feels any symptoms of illness:

      1. cough
      2. shortness of breath or difficulty breathing
      3. bluish lips or face
      4. loss of taste (dysgeusia)/smell (anosmia)
      5. fatigue
      6. chest pain/tightness
      7. nausea, vomiting, diarrhea
      8. headache
      9. dizziness
      10. purple skin lesion on feet similar to the measles or chickenpox
11. new confusion
12. difficulty waking and/or increased somnolence
13. chills, repeated shaking with chills, rigors
14. muscle aches
15. sore throat
16. temperature >100.4 degrees F
17. any other new symptoms as reported by the CDC

2. Pulse Oximetry
   A. Necessity would be to check oxygen saturation. (In this document, pulse oximetry will be used to assess disease state and not to assess fitness level.) Normal would be considered greater than 90-92% and pulse rate less than 100.

3. Agent to assess smell and taste (Jellybean Test aka RetroNasal Olfaction Test).

4. Acetaminophen as an analgesic and antipyretic
   A. Distribution of medication should be monitored and documented per team physician guidelines and/or standing orders.

5. Personal Protective Equipment (PPE)
   A. For the team physician and ATC: PPE including gloves, eye protection, personal mask (n95 mask preferred for medical staff), and covering for clothing.
   B. For athletes: may use surgical or cloth mask covering, and in individual cases, gloves.

Working guideline for return to training venue and team training:
1. Consideration should be given to testing the team physician, ATC, medical and coaching staff, management, and any individual, regardless of role, who would have access to the individual athlete, equipment, or uniforms.
2. Athletes returning with a positive history of COVID-19 infection
   A. Physician clearance would be required before consideration of inclusion in group training.
3. All other returning athletes should work 1:1 with the team physician and/or ATC to complete a baseline FDA-approved rapid COVID-19 antibody test.
   A. As athletes can be potentially coming from different regions of the state/country or may have traveled abroad, with each area having individual exposure risk, this test is done to establish if there has been an unknown exposure to COVID-19 or if an athlete is asymptotically shedding the COVID-19 virus.
      1. While the use of antibody testing remains controversial at this time, with concerns including whether the presence of antibody truly confers immunity, how long the immunity will last, and if there is potential for reinfection of COVID-19, it is necessary to identify athletes who test positive prior to exposing other teammates and/or personnel and a database can be established for future research and monitoring.
   B. If testing of athletes is done on-site, medical personnel will use PPE for collection of samples. The athlete should also be in PPE until the time of the test, at which point one glove may be removed to perform fingerstick. The designated testing site should be cleaned and disinfected using an EPA-registered disinfectant against COVID-19 before testing any athlete and between each athlete. Please note that the longevity of immunity to COVID-19 has not yet been established to date.

Athletes who test positive on initial FDA-approved rapid COVID-19 antibody test.
1. If the athlete tests positive for IgM (+ IgM), this athlete has acute COVID-19 and should be removed from play and begin a 2-week self-isolation.
2. The team physician and/or certified athletic trainer should monitor the affected athlete daily for disease progression and resolution. Treatment specific to COVID-19 is determined by symptoms and based on current CDC guidelines.
3. Positive test results should be reported to state and/or local health agencies as per agency protocols especially if a contact-tracing system is in place. It is recommended to have a standing relationship with these agencies and activate that relationship if a COVID-19 + IgM athlete is discovered on rapid COVID-19 antibody testing. This is done to prevent potential future spread within the organization and/or general public based upon the athlete’s contacts.

4. There should be consideration of discussion of avenues of access to and/or treatment for mental health support in the presence of a positive test.

5. If an athlete tests positive for IgG (+IgG), this indicates that an athlete has been exposed to COVID-19. It is unknown as of the publication of this document if this will protect the individual from future infection and how much or how long immunity may be conferred to the athlete.

6. Clearance for return to training must be determined by the team physician.

Return to training in the athlete that initially tested + IgM on rapid antibody test:
1. Once the athlete has completed a 2-week self-isolation period, then it is permissible to re-test on day #15 to determine if the athlete has built an immune response to the virus by generation of an IgG positive result.
2. It is essential to make sure the athlete has had a normal temperature (< 100.4 deg F) consecutively during the final 3 days of isolation (days 12,13,14) and has taken no antipyretics on these days. If a temperature develops, the athlete must reset the afebrile day count to 0 and monitor temperature until the athlete has 3 consecutive afebrile days. Again, there can be no antipyretics taken while monitoring for the final 3 afebrile days to be released from self-isolation.
3. If the athlete retests +IgM again after 2 weeks of isolation, then the athlete must go back into self-isolation and can retest again on day 26 from the start of symptoms. Studies show the COVID-19 virus may last in the system for 25 days.
4. Clearance for return to training must be determined by the team physician.

Athletes who test negative on initial FDA-approved rapid COVID-19 antibody test who develop signs and symptoms of COVID-19:
1. Athletes who develop signs and symptoms of COVID-19 who initially tested negative for COVID-19 antibodies should be placed on a 2-week self-isolation.
2. The team physician and/or certified athletic trainer should monitor the affected athlete daily for disease progression and resolution. Treatment specific to COVID-19 is determined by symptoms and based on current CDC guidelines.
3. Rapid COVID-19 antibody test can be repeated at the end of the 2-week self isolation on day #15 to determine if the athlete has built an immune response to the virus by generation of an IgG positive result.
4. It is essential to make sure the athlete has had a normal temperature (< 100.4 deg F) consecutively during the final 3 days of isolation (days 12,13,14) and has taken no antipyretics on these days. If a temperature develops, the athlete must reset the afebrile day count to 0 and monitor temperature until the athlete has 3 consecutive afebrile days. Again, there can be no antipyretics taken while monitoring for the final 3 afebrile days to be released from self-isolation.
5. Clearance for return to training must be determined by the team physician.

Athletes who test negative on initial FDA-approved rapid COVID-19 antibody test:
1. Individual athletes who are IgM negative(-IgM) should be screened daily for signs and symptoms of COVID-19 infection before entering the training facility.
Guideline for COVID-19 test results documentation for all athletes:
1. It is recommended that ALL COVID-19 testing results be uploaded to the athlete’s phone which is password protected for immediate access. This includes any testing done by the athlete’s personal physician or an urgent care. The athlete should provide documentation and result of testing to the team physician or certified athletic trainer of any testing not ordered by the team physician or certified athletic trainer.
2. Team physician and/or ATC should place the original copy of the athlete’s test results in the athlete’s medical file/electronic medical record.

Working guidelines for training facilities:
1. Training areas should have a handwashing facility with soap and water as well as hand sanitizer with at least 60 % alcohol for athletes to use frequently throughout the day.
2. Training facilities and equipment should be frequently cleaned and disinfected throughout the day using an EPA-registered disinfectant against COVID-19. Equipment should be cleaned and disinfected after each use by an athlete.
3. There should be no sharing of practice gear, uniforms, or any personal hygiene products. It is recommended that sports equipment should be individualized whenever possible, i.e., use of individual baseball bats or lacrosse sticks.
4. ATC’s should consider the use of easily visualized social distancing markers at training facilities to help athletes/staff adhere to CDC guidelines. Consider using training equipment in a circuit to keep athletes moving one way within a training facility.
5. There should be access to individualized, disposable vessels for water and other sports drinks, if applicable.
6. Teams must consider having all athletes wear masks and gloves when using equipment.
7. Reserve athletes waiting on the bench (not in current play) for a training drill should be wearing masks.
8. It is recommended to try to maintain social distancing of at least six feet circumference in the training facility as “stay at home” orders are lifted. There is emerging evidence that this distance may need to be increased, but at present, guidelines remain at six feet. This may cut down transmission in the case of an infected, asymptomatic athlete training within that session. Symptoms may not show in an asymptomatic athlete for 2 to 14 days after exposure.
9. Access to athletic facilities should be limited to athletes, medical personnel, and coaching staff.
10. Athletes who need access to the ATC staff should be scheduled individually to control the number of people in the training room. If this appointment concerns a potential illness, not an injury, the ATC should wear PPE and the athlete should be masked and gloved. Instructions should be given by the team physician on the proper donning and doffing of PPE. The athletic training facility should be thoroughly cleaned and disinfected after every ill athlete encounter using an EPA-registered disinfectant against COVID-19 on surfaces upon which the athlete has had contact.
11. Any athlete exposed to a positive COVID-19 person must self-isolate until a rapid antibody test is performed again to confirm no acute infection.
12. Staff working at a facility with a team should also adhere to working guidelines above.
13. Non-contact sports: these guidelines can be applicable to no more than 10 athletes/staff in total at training sessions practicing social distancing at six feet apart.
14. Contact sports: these guidelines can be applicable to individual training and non-contact drills/training of no more than 10 athletes/staff in total at training sessions practicing social distancing at six feet apart. Further research is needed to facilitate incorporation of contact training drills into the program.
Recommended continued safety guidelines:

1. Continue to practice CDC-recommended, 20-second hand washing skills emphasizing each finger and between fingers after coughing, sneezing, or blowing nose, before eating or preparing food, after using the restroom, after using the training room, and before using team equipment. Twenty seconds is the equivalent of singing “Happy Birthday” twice.

2. Avoid touching the eyes, nose, or face.

3. Sneeze or cough into the bend of the elbow or into a tissue which is then immediately thrown away.

4. Continue to protect yourself from others outside of training by adhering to CDC guidelines.
   A. Maintain social distancing with at least six feet of distance in circumference between you and anyone else in public.
   B. Wear a mask when in public to prevent disease transmission.

5. Avoid going out in public as much as possible, and if possible, have someone else obtain necessities for the athlete, i.e., groceries, prescriptions, etc.

6. Athletes should be instructed to inform the team ATC if they are feeling ill and should self-isolate to decrease exposure to others until assessment can be completed by the medical staff.

7. If the athlete is ill, the medical personnel should perform an evaluation including a detailed history of present illness, potential exposure, and physical examination.

8. Acetaminophen may be used for symptoms of pain or fever associated with flu-like illness. Caution on the use of prescription or over-the-counter anti-inflammatories such as Motrin, Aleve, Ibuprofen, Advil, naprosyn, or naproxen.
   A. Distribution of medication should be monitored and documented per team physician guidelines and/or standing orders.

9. The athlete should maintain a copy of all rapid COVID-19 testing at all times. Storage on a cell phone is recommended. It is recommended that the original test results be placed in the ATC and team physician medical record/EMR.
Resources


