



## Goal

1. To assist team physicians in helping athletes return to training in a 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.
2. 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 multidiscipline specialists, including Family Medicine, Internal Medicine, Infectious Disease, and Certified Athletic Trainers (ATCs), 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. World Rugby, Return to Play Sports Coalition, Return to Activity Korey Stringer Institute, NAIA, and NATA were reviewed for revision 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. These guidelines can be utilized by ATC’s of local state and school organizations.

# Return to Training: Management of the Athlete from the COVID-19 Pandemic

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## 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 emerge 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.
  1. 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 (*see updated COVID-19 Athlete Screening Questionnaire in Appendix A*):
    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).  
<https://www.scientificamerican.com/article/bring-science-home-jelly-bean-taste-smell/>
  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.
    - i. 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.

### **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. Team physician to consult with cardiology for the potential use of ECG, 2D Echo and high sensitive Troponin I test in ruling out myocarditis. After the test results are negative, team physicians should work with ATC to have the athlete do a graduated aerobic return to training plan to

monitor for any cardiac symptoms or exercise intolerance.

### **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. Team physician to consult with cardiology for ECG, 2D Echo and high sensitive Troponin I test in ruling out myocarditis. After the test results are negative, team physicians should work with ATC to have the athlete do a graduated aerobic return to training plan to monitor for any cardiac symptoms or exercise intolerance.

### **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.
  - a. If any signs or symptoms are present, then the athlete is to return home and not participate in training that day and instructed to monitor temperature.
    - i. Athletes reporting skin changes, chest pain, difficulty breathing, and/or difficulty waking should be referred to the team physician immediately for further evaluation.
  - b. Clearance for return to training must be determined by the team physician.

2. If the athlete is asymptomatic, check temperature in AM before entering the training facility.
  - a. If temperature >100.4 deg F, then the athlete should not return to training that day and will need to monitor for persistent fever.
  - b. If temperature < 100.4 deg F, then the athlete is permitted to train that day.
3. Check the athlete's heart rate and pulse oximetry if cough or shortness of breath develops or fitness/endurance suddenly declines.
4. The above process (steps 1-3) is to be done daily.

### **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.
  - a. Athletes reporting skin changes, chest pain, difficulty breathing, and/or difficulty waking should be referred to the team physician immediately for further evaluation.
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.

## **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.
3. If cardiac clearance is required for an athlete then a copy of their ECG, 2D Echo high sensitive Troponin I test, and/or cardiac consultation should be placed in the athlete's 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. Hands should be washed before entering the facility, after using equipment, and upon exit of the facility.
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. Cloth medical equipment should be washed in hot water with detergent for proper cleaning as per CDC guidelines. If your institution does not have access to a proper washer and dryer for cleaning the ATC should inform administration and the Team Physician.
5. 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 one-direction circuit stations to keep athletes moving safely one-way within a training facility. Athletes should be six feet apart during training-

this can be done by the use of rubber markers. Teams must consider having all athletes wear masks and gloves when using equipment. If six feet of social distancing cannot be maintained between each athlete, then the maximum number of individuals within the training facility must be decreased until six-foot distance is obtained. There is some emerging evidence that this distance may need to be increased, but at present, guidelines remain at six feet.

6. Reserve athletes waiting on the bench (not in current play) for a training drill should be wearing masks.
7. There should be access to individualized, disposable vessels for water and other sports drinks, if applicable.
8. Access to athletic facilities should be limited to athletes, medical personnel, and coaching staff.
9. Staff working at a facility with a team should also adhere to working guidelines above.
10. Non-contact sports: these guidelines can be applicable with CDC and state recommended number of people (athletes and staff) in training sessions practicing social distancing at six feet apart.
11. Contact sports: these CDC and state guidelines can be applicable to individual training and non-contact drills/training for athletes and staff at training sessions practicing social distancing at six feet apart. Further research is needed to facilitate incorporation of contact training drills into the program.
12. Hydrotherapy equipment such as: whirlpools, pools, tubs, and spas, must be cleaned and disinfected after every use. The use of commercial products like bromine should be used in hydrotherapy facilities and/or EPA-registered disinfectant against COVID-19.
13. Consider cleaning floors and other hard surface areas at the end of each day with EPA-registered disinfectant against COVID-19 by facility maintenance personnel.
14. While showering reduces the risk of skin disorders, it also increases the amount of time athletes are in close proximity. Social distancing rules should encourage teams to have athletes shower at home and reduce close proximity activities in the locker room. Uniforms should be worn to and from training facilities and removed and laundered daily.

## **Working guidelines for Athletic Training:**

1. Certified Athletic Trainers should consider the establishment of a COVID-19 Response Team. This team should develop policy and procedures for return to sport at their institution. The team should include the following members:
  - a. Certified Athletic Trainer
  - b. Team Physician
  - c. Athletic Director
  - d. School Nurse
  - e. Public Health Official
2. Some state Sports Medicine Advisory Committee's have recommended the establishment of an actual COVID-19 Officer who would coordinate the COVID-19 response within the institution.
3. Certified athletic trainers should prepare their athletes for the return to physical activity after the deconditioning post stay at home orders, address heat acclimation concerns, address preseason practice considerations such as updating health histories, and address conditioning and practice session concerns.
4. Certified athletic trainers should update their Emergency Action Plans (EAP) for each venue used due to the potential cardiovascular, respiratory, or neurological complications from COVID-19. (An example of which is found in Appendix 2). These EAP plans should include the following:
  - a. Location of nearest automated external defibrillator (AED);
  - b. Location of venue entrance for emergency vehicles or equipment;
  - c. Recommend all coaches are CPR and First Aid Certified;
  - d. Consideration of the use of PPE to protect against COVID-19 exposure for any athlete that needs transport to the Emergency Department or any health care facility;
  - e. The EAP should be reviewed, practiced, and rehearsed before the first return to sport activity is begun.
5. 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.
6. If an athlete needs hands-on treatment by the ATC, the ATC should wear proper PPE; i.e., gown, goggles, gloves, and, if possible, a N95 mask. Athletes should also wear a N95 mask, if possible, during treatment sessions.
  - a. Athletic trainers should consider adhering to one taping station/treatment table with proper medical supplies in each station; i.e., different kinds of tape, ace wrap, scissors, etc.
  - b. Proper cleaning and disinfecting of taping stations/treatment tables and equipment used with an EPA-registered disinfectant against COVID-19 should be done after every athlete contact.
7. All medical personnel should consider keeping cleaning supplies with their equipment; i.e., proper disinfecting wipes or spray, hand sanitizer, clean towels, EPA-registered disinfectant against COVID-19 and should be used appropriately after every athlete contact.
8. Consider handling of medical equipment and supplies only by medical personnel. Athletes or ATC students/interns should not go into a medical kit/bag or use medical personnel's equipment.
9. Consider thorough cleaning of the medical kit checked out for away competition. The inside of the medical kit should be inspected by the athletic trainer and cleaned with EPA-registered disinfectant against COVID-19.
10. On the field or courtside, the ATC should maintain a 6-foot distance from the athlete, staff, and team unless an emergency situation ensues. Appropriate PPE should be worn.

### **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.
10. Athletes who test positive for COVID require medical clearance before returning to training and/or competition as further testing and/or recommendation may be required.
11. In response to COVID-19, ATCs should consider updating their EAPs with their institutions.

**APPENDIX 1: COVID-19 ATHLETE SCREENING QUESTIONNAIRE**

Student Name: \_\_\_\_\_ ID# \_\_\_\_\_

**COVID-19 ATHLETE PRE-SCREENING QUESTIONNAIRE**

We appreciate your cooperation and patience in helping to keep our students and staff safe and healthy.

**\*\*This completed form must be turned in to Department of Athletics with your Physical paperwork\*\***

<b>1. IN THE LAST TWO WEEKS Have you experienced:</b>	<b>YES</b>	<b>NO</b>
Fever (100.4°+)?		
Coughing?		
Sore throat?		
Headache?		
Muscle aches?		
Shortness of breath or difficulty breathing?		
Persistent muscle aches?		
Dizziness?		
New confusion or unable to wake?		
Chills or repeated shaking chills?		
Loss of taste or smell?		
Bluish lips or face?		
Purple skin lesions on feet?		
Chest pain, pressure, or tightness?		
Fatigue or difficulty with exercise?		
Nausea, vomiting, or diarrhea?		

<b>2. Have you had a household contact or cared for a person infected with current or past Coronavirus? (if Yes, who?)</b>		
<b>3. Do you have moderate to severe asthma, a heart condition, diabetes, pre-existing kidney disease, or compromised immune system? (explain):</b>		
<b>4. Have you been diagnosed or tested positive for COVID-19 infection? (date):</b>		

<p><b>a. During the infection did you suffer from chest pain, pressure, tightness or heaviness, or experience difficulty breathing or unusual shortness of breath? (explain):</b></p>		
<p><b>b. Since the infection, have you had new chest pain or pressure with exercise, new shortness of breath with exercise or decreased exercise tolerance? (explain):</b></p>		
<p><b>5. Did you receive treatment for COVID-19 infection and if so, what was the treatment course? (treatment):</b></p>		
<p><b>6. Did you receive follow-up care with your primary care physician after having COVID-19? (date and physician name):</b></p>		
<p><b>7. Were you hospitalized after being diagnosed with COVID-19? (Dates and institution)</b></p>		
<p><b>8. Did you see a cardiologist or have a cardiac clearance with ECG, 2D Echo and high sensitive Troponin I test? (date and physician name):</b></p>		

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Parent/Guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**APPENDIX 2: Emergency Action Plan Template**  
**EMERGENCY ACTION PLAN STADIUM**

**Emergency Personnel:** Physicians, Certified Athletic Trainers, Paramedics, Public Safety Officers, coaches, managers, athletes, administrators, bystanders, COVID-19 Officer

**Emergency Communication:**

Direct contact with Paramedics

Direct contact with Public Safety (if in attendance)

**Landline phone stadium: list number**

Head ATC Name and number

9-1-1 if necessary

**Emergency Equipment:**

Game: Team Physician, Paramedics, AED, athletic training kit, splint bag, spine board and accessories, cervical collar, BVM, OPA, oxygen.

**Sideline Equipment in Protection of COVID-19 Exposure:** face coverings/cloth masks, eye protection for athletes, hand sanitizer at least 60% alcohol.

**Roles of First Responders:**

- Field ATC/Team Physician screens to determine severity of injury
- Assistant Field Athletic Trainer/PT or Team Physician activates EMS/EAP
- Emergency equipment retrieval by Team Physician, ATC, or manager
- Direct EMS to scene
- Appropriate gates are opened
- Designate individual(s) to direct EMS to victim
- Scene control: limit scene to first aid providers and move bystanders away from area
- If possible, have insurance/workers' compensation information ready for transport

**After the Event:**

The Head Athletic Trainer must be notified of all emergencies. Contact the Head Athletic Trainer and Team Physician to let them know the status of the patient and where he/she is being taken.

**Document** the injury/event. Include the procedures followed and the condition of the athlete when he/she was transported.

**If there is an AED deployment:** Immediately after the event contact Local Project Heartbeat at (phone number).  
**Equipment for athletes in protection of COVID-19 exposure with public/friends/family:** face coverings/cloth masks, eye protection, hand sanitizer at least 60% alcohol.

**Venue Directions:**

**STADIUM** is located near (place in detailed directions)

This venue is visible from (add location street). Enter campus from (add directions). The entrance is (add location in relationship to field/court).

**NON-EMS ILLNESS/INJURY**

(If in doubt, call the Head Athletic Trainer.)

**Procedures to follow:**

1. Athletic Trainer/coach/first responder in charge **stabilizes** and prepares athlete for transport.
2. **Transport** the athlete to the locker room/evaluation area.
3. **Evaluate** and provide first aid. If necessary, prepare athlete for transport to hospital or physician's office. Consider use of proper PPE to protect against exposure to COVID-19.
4. **Check insurance.** Refer the patient to a facility where his/her insurance will be utilized. If the injury occurs before 5 p.m. during the week, call the Team Physician's office directly. If after 5 p.m. or on the weekends, call the Team Physician and they will advise ATC and the medical team as to where the athlete will be taken.

**Before 8pm:** Add in Urgent Care or desired medical facility

5. **Transportation** to the medical facility is not the responsibility of the athletic trainer. If possible utilize friends, teammates, coaches, or managers.
6. **Document** procedures followed and the condition of the athlete when he/she was transported.

**PHONE NUMBERS**

**Public Safety Emergency: local number or 9-1-1**

**Head Athletic Trainer: add name and phone number**

**Team Physician: add name and phone number**

**Non-emergency Public Safety: add number**

**ADD MAP OF VENUE**

## Resources:

Bernhardt, DT, Roberts, WO, eds. (2019). *Preparticipation Physical Examination (PPE) Monograph 5<sup>th</sup> Edition*. Itasca, IL: American Academy of Pediatrics.

Cutler, D, et al. How will COVID-19 Affect the Health Care Economy? *JAMA Health Forum*. April 9, 2020. <http://jamanetwork.com/journals/jama/pages/coronavirus-alert>.

Hadaya J, Schumm M, Livingston EH. Testing Individuals for Coronavirus Disease 2019 (COVID-19). *JAMA*. Published online April 01, 2020. doi:10.1001/jama.2020.5388. <https://jamanetwork.com/journals/jama/fullarticle/2764238>.

Hartley, DM, Perencevich EN, et al. Public Health Interventions for COVID-19: Emerging Evidence and Implications for an Evolving Health Crisis. *JAMA*. April 10, 2020. <https://jamanetwork.com/journals/jama/pages/coronavirus-alert>.

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Paules CI, Marston HD, Fauci AS, et al. Coronovirus Infections-More Than Just the Common Cold. *JAMA* January 23, 2020. <https://jamanetwork.com/journals/jama/fullarticle/2759815>.

## Online Resources:

[https://ais.gov.au/health-wellbeing/covid-19#ais\\_framework\\_for\\_rebooting\\_sport](https://ais.gov.au/health-wellbeing/covid-19#ais_framework_for_rebooting_sport)

<https://blogs.bmj.com/bjbm/2020/04/24/the-resurgence-of-sport-in-the-wake-of-covid-19-cardiac-considerations-in-competitive-athletes/>

<http://www.cdc.gov/coronavirus/2019-ncov>

<https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-business-response.html>

<https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/disinfecting-your-home.html>

<https://www.covid19treatmentguidelines.nih.gov/concomitant-medications/>

<https://www.forbes.com/sites/karenweaver/2020/05/09/return-to-play-guidance-emerges-for-college-sports-colleges/#5de111dc1e9a>

<https://www.naia.org/covid19/index>

[https://www.nata.org/sites/default/files/covid\\_19\\_return-to-sport\\_considerations\\_for\\_secondary\\_school\\_at\\_1.pdf](https://www.nata.org/sites/default/files/covid_19_return-to-sport_considerations_for_secondary_school_at_1.pdf)

<https://www.ncaa.org/sport-science-institute/core-principles-resocialization-collegiate-sport>

<https://www.teamusa.org/Coronavirus-Updates>

<https://www.uscah.com/blog/>

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019>