MEDICAL PROVIDER CLEARANCE TO RETURN TO SCHOOL

FOR STUDENT SENT HOME FROM SCHOOL OR CALLED OUT ABSENT DUE TO ILLNESS

Please have your medical provider sign, date and stamp this document for their return to school.

STUDENT: ___________________________ GRADE: ______ DATE SENT HOME: ___________

This child has presented to the School Nurse or was absent from school with the following symptoms that are consistent with COVID-19

Fever Of: _______ Time: _______ Cough ___ Shortness of Breath or Difficulty Breathing ___
Muscle/Body Aches _____ Headache _____ New Loss of Taste or Smell _____ Sore Throat ___
Congestion or Runny Nose _____ Nausea/Vomiting/Diarrhea _____
Other ________________________________

Dear Medical Provider: 

COVID-19 Test Ordered, Date: ________________________________
COVID-19 Test Not Indicated: ____________ (MD Signature) ________________________________
Date Student May Return to School On: ________________________________

DOCTOR’S SIGNATURE: ___________________________ DATE ___________ STAMP __________________

Additional Comments Including COVID-19 Test Results: ____________________________________________

This Student May Return to School When All of the Following Criteria Have Been Met:

• Doctor’s Clearance to return
• COVID-19 Test with Negative Results, If Indicated by the Evaluating Doctor
• No Fever x 24 Hours (Without the Use of Fever Reducing Medicine)
• Symptom Free x 24 Hours