

MEDICAL PROVIDER CLEARANCE TO RETURN TO SCHOOL

Return to school protocol must follow New York State Health and Education protocol (updated 9/30/20) and shall include, at minimum:

1. Documentation of evaluation by a healthcare provider indicating a diagnosis of a chronic condition with unchanged symptoms or a confirmed acute illness AND COVID-19 is not suspected
2. A negative COVID-19 test result if required by the health care provider (stay out of school until results are confirmed)
3. No fever (temperature less than 100 degrees F) without the use of fever reducing medicine for 24 hours and symptom improvement

Student: _____ Grade: _____ Date Sent Home: _____

Return completed form to school RN within 48 hours and before your child returns to school.

This child exhibited the following symptom(s) that are consistent with COVID-19.

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

Medical Provider Clearance

Please indicate the alternate diagnosis for this child who exhibited symptoms consistent with COVID-19 - refer to #1 in the above medical provider clearance to return to school.

*NYSDOH (9/30/20) : *unconfirmed acute illness, such as URI or viral gastroenteritis, will not suffice*

Diagnosis _____

COVID-19 testing required by health care provider (HCP please indicate): YES NO

Student is cleared to return to school on _____ (Date)

PRINT Provider Name _____

Provider Address _____

Provider Phone _____

Provider SIGNATURE _____ DATE _____

Additional comments including COVID-19 Results _____

Attach copy of COVID-19 Test result for the child.