

Dear Medical Care Provider,

The Department of Health guidance for students returning to school requires that schools screen students for COVID-19 symptoms, which include:

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| <input type="checkbox"/> Fever (100.4°F) or chills | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Recent loss of taste or smell |
| <input type="checkbox"/> Shortness of breath or difficulty breathing | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Unusual fatigue | <input type="checkbox"/> Congestion or runny nose |
| <input type="checkbox"/> Muscle or body aches | <input type="checkbox"/> Nausea or vomiting |
| | <input type="checkbox"/> Diarrhea |

You are receiving this because a student or staff at _____ school district has one or more of these symptoms, and they cannot return to school until they have met one of the following criteria:

1. If the person does not get tested for COVID-19, the student will be able to return to in-person instruction after 10 days from onset of symptoms provided that their symptoms are improving, **AND** they have been fever free for 24 hours without taking fever reducing medications. This person first had symptoms on _____, and if the above criteria is met, the earliest they may return to school is _____.
2. The person will be able to return to school earlier if he/she has not had a known exposure to someone with COVID-19; **AND** a negative COVID-19 PCR test; **AND** has not had a fever for 24 hours in the absence of fever reducing medications; **AND** if their symptoms are improving.
3. **The person will be able to return to school earlier if he/she is diagnosed by their healthcare provider with a different diagnosis.**

This form is regarding the third criteria listed above. If you determine the student as having a COVID-19 symptom due to a different diagnosis, please complete the form below.

Medical Facility Name: _____ Address: _____

Medical Provider Name: _____ City: _____

Students Name: _____

I have evaluated _____ for the COVID-19 symptom(s) _____

and have diagnosed the student's symptom(s) to be caused by _____

_____, not COVID-19.

Will these symptom(s) be likely to continue to occur? Yes: _____ No: _____

Medical Provider signature: _____ Date: _____
