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:

- Fever (100.4°F) or chills
- Cough
- Shortness of breath or difficulty breathing
- Unusual fatigue
- Muscle or body aches
- Headache
- Recent loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- 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: _______________________

____________________________________________________________________________________