

MEDICAL PROVIDER CLEARANCE TO RETURN TO SCHOOL

Please have your medical provider sign this document and return it to the school nurse BEFORE sending your child back to school

Student: _____ Grade: _____ Date sent home: _____

This child has presented to the School Nurse with the following symptoms that are consistent with COVID-19

Returning to School after Illness

Schools must follow CDC, NYSDOH and Local Health Departments for "Return to School" guidance.

Dear Medical Provider,

Please indicate your diagnosis for this child who was sent home from school with *possible* COVID-19 symptoms.

Diagnosis _____

This child tested **NEGATIVE/POSITIVE** for COVID-19 and may return to school on _____
Date

SIGNATURE _____ DATE _____

Additional comments including COVID-19 test results _____

Per NYSDOH Interim Guidance for in-person instruction at Pre-k to grade 12 schools during the COVID-19 public health emergency, page 3.

This return to school protocol shall include, *at minimum*, documentation from a health care provider following evaluation, negative COVID-19 diagnostic test result, and symptom resolution, or if COVID-19 positive, release from isolation.