COVID-19 Return to School Form

Your student is exhibiting symptoms consistent with COVID-19. In order to return to school, he/she must have an alternative diagnosis by an approved healthcare provider (MD/DO/PAC/NP) with a note stating it is appropriate for them to return to school or follow the return to school criteria from the Indiana Department of Health. Please note – a negative test does not provide clearance for student to return earlier then allowable by the Indiana Department of Health.

(https://www.coronavirus.in.gov

Student Name: _____ DOB: _____

Date of Symptom Onset: _____

Symptoms Observed (Please check below as applies)

- ☐ Fever or Chills
- ☐ Cough or Shortness of Breath
- ☐ Headache (not due to previous medical conditions)
- ☐ New loss of taste or smell
- ☐ Sore Throat
- ☐ Nausea/Vomiting/Diarrhea

If not seen by Healthcare provider return date will be _____ and student will be required to stay mask 100%, except when eating and drinking *.

For Healthcare Provider Use Only:

- ☐ **Student has an alternate diagnosis and a note from provider stating they believe it's appropriate for the student to return to school.**

  Diagnosis: _____

  May Return to School on: _____

- ☐ **At least 5 days have passed since symptoms first appeared, symptoms have improved, and the student has not had a fever (>100.0) for 24 hours without fever reducing medication.**
- ☐ **Student DOES NOT have an alternate diagnosis and provider believes it is appropriate for them to follow return to school criteria from the Indiana State Department of Health.**

Evaluator's Name (print): _____ Date of Evaluation: _____

Office Phone: _____

Evaluator's Signature: _____

***Students returning in 5 days, MUST stay mask 100% of the time (other than when eating or drinking) to complete the 10 isolation. If they DO NOT stay mask 100 % they will need to stay home for the entire 10 days.**