Return to School Form

Student Name:_____

DOB: _____

Date of Visit:_____

Date Student May Return:_____

Student referred for COVID19 testing:

- ○ No (if no explain)
- ○ Yes

Activity Restrictions:

- ○ No
- ○ Yes (explain)

Medication ordered during school hours?

- ○ No
- ○ Yes (include separate medication order)

Additional comments:

The student was evaluated by: _____

Signature (MD, DO, PA, CRNP)

School may communicate with provider above concerning recent visit:

- ○ No
- ○ Yes

_____

Signature of Parent/Guardian

Health Office Use Only

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School Nurse_____

Date of Reentry_____

Outcome:

_____Alternate dx documentation
_____Negative COVID test
_____Positive COVID test
_____10 day isolation
_____14 day isolation

Forms Received:

_____Test results
_____Medication Orders
_____Physician documentation