TUCKAHOE
UNION FREE SCHOOL DISTRICT

STAFF

MEDICAL PROVIDER CLEARANCE FOR COVID SYMPTOMS TO RETURN TO SCHOOL

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

Staff Member:_____ Date Sent Home/Absent:_____

This staff member has presented or reported to the School Nurse with the following symptoms that are consistent with COVID-19 but not limited to: Fever of _____ Time:_____ Cough____ Shortness of breath or difficulty breathing_____ Fatigue/Tired ____ Muscle/Body Aches____ Headache____ New loss of taste or smell _____ Sore throat ___ Congestion or runny nose___ Nausea/Vomiting/Diarrhea _____

Other:_____

Returning to School After Illness: Schools must follow CDC, NYSDOH, and Westchester County Department of Health "Return to School" Guidance.

Dear Medical Provider:
Please indicate your diagnosis for this staff member who was sent home from school with possible COVID-19 symptoms.

Diagnosis_____

This Staff Member: ☐ **Was Tested for COVID-19** ☐ **Was Not Tested for COVID-19**

COVID-19 PCR Test Results**
***Negative Abbott ID NOW COVID-19 POC molecular rapid test**
and all COVID-19 Antigen tests no longer accepted
Cepheid Xpert Xpress COVID-19 Rapid molecular test (Accepted)

☐ **Positive** ☐ **Negative**

And may return to school on _____
Date

_____ _____
Physician Signature Date

Additional comments:

_____

****This form and copy of the test results must be returned to the school nurse before reentry.**