TUCKAHOE
UNION FREE SCHOOL DISTRICT

STUDENT
MEDICAL PROVIDER CLEARANCE 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

Student Name:_____ Grade:_____ Date Sent Home/Absent_____

This student has presented with or it has been reported to the School Nurse 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 student who was sent home from school with possible COVID-19 symptoms.

Diagnosis_____

This Student: ☐ **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 are no longer accepted**

Cepheid Xpert Xpress COVID-19 Rapid molecular test (Accepted)

☐ **Positive** ☐ **Negative**

And may return to school on Date _____

_____ _____

Physician Signature Date

****Sibling(s) must stay home if the COVID-19 test is administered until negative results are confirmed.**

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

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.