Kathleen Cotilletta

Principal

76 Park Blvd.

Malverne, NY 11565

516-599-7328

MEDICAL PROVIDER CLEARANCE TO RETURN TO SCHOOL

FOR STUDENT SENT HOME FROM SCHOOL OR CALLED OUT ABSENT DUE TO ILLNESS

Please have your medical provider sign, date and stamp this document for their return to school.

STUDENT: ______________________________GRADE: ______ DATE SENT HOME: ____________

This child has presented to the School Nurse or was absent from school with the following symptoms that are consistent with COVID-19

Fever Of: ________ Time: ________ Cough _____ Shortness of Breath or Difficulty Breathing ____

Muscle/Body Aches _______ Headache ______ New Loss of Taste or Smell _______ Sore Throat _____

Congestion or Runny Nose _______ Nausea/Vomiting/Diarrhea _______

Other ____

Dear Medical Provider: Date of Exam: __________

COVID-19 Test Ordered, Date: ______________________________________

COVID-19 Test Not Indicated: _______________ (MD Signature) _________________________________

Date Student May Return to School On: _______________________________

DOCTOR'S SIGNATURE: ____________________________ **DATE** _____________ **STAMP**____________________

Additional Comments Including COVID-19 Test Results: ____

This Student May Return to School When All of the Following Criteria Have Been Met:

- Doctor's Clearance to return
- COVID-19 Test with Negative Results, If Indicated by the Evaluating Doctor
- No Fever x 24 Hours (Without the Use of Fever Reducing Medicine)
- Symptom Free x 24 Hours