



COVID-19 School Clearance Form

To be filled out by Medical Personnel

STUDENT: _____

PARENT: _____

PHONE: _____

GRADE: _____

I. SCREENING DATA:

- Screening for COVID-19 exposure**
 - Determined as Not exposed or Exposed—Date of exposure: _____
- Symptoms, screening for COVID-19**—Date of onset of symptoms: _____
 - COVID-19 Symptoms Present; No COVID Symptoms Present; Other diagnosis
- COVID-19 confirmed by test**—Date of test: _____ Date of result: _____

II. IMMEDIATE DISPOSITION

- QUARANTINE FOR TESTING:**
 - May return to school on: _____ if no symptoms develop.
- QUARANTINE FOR EXPOSURE:**
 - Quarantine for _____ days starting on _____ ending on _____.
 - May return to school on: _____ if no symptoms develop.
- ISOLATION FOR CONFIRMED COVID-19 or COVID-19 SYMPTOMS**
 - Isolate for _____ days starting on _____ and ending on _____.
 - May return to school on: _____ if 24 hours free of symptoms and fever-free for 24 hours without the use of fever-reducing medications.
- NO QUARANTINE/ISOLATION REQUIRED**

III. FINAL DISPOSITION:

- CLEARED TO RETURN TO SCHOOL AS OF:** _____
(COVID-19 or NON-COVID-19)
- UNABLE TO RETURN TO SCHOOL DUE TO EFFECTS OF COVID-19.**
 1. See Section II for return to school date.
 2. Please notify school immediately. Absences will be excused.

Provider Signature

Date