BETHLEHEM CENTRAL SCHOOL DISTRICT

MEDICAL PROVIDER CLEARANCE FORM DURING COVID-19

STUDENT NAME: _____ GRADE: _____

DATE(S) HOME WITH SYMPTOMS: _____ OR DATE SENT HOME WITH SYMPTOMS: _____

Dear Parent/Guardian:
Please have your child's medical provider complete the section below and return it to the school nurse BEFORE sending your child back to school. Please contact your child's school nurse with any questions or concerns.
Thank you.

TO BE COMPLETED BY MEDICAL PROVIDER ONLY

Please note the following Requirements for Returning to School following a student's absence or dismissal from school due to possible COVID-19 symptoms, as noted by CDC. Please check the appropriate box for your patient:

☐ Evaluation by the student's medical provider **AND** COVID-19 testing.

If the COVID test is NEGATIVE:

- You must provide a Medical Provider Release stating "student cleared to return to school on (date)" AND provide proof of the negative COVID-19 test. Provider should enter information below.

  IMPORTANT: If symptoms persist due to a *chronic condition,* please include that information regarding chronic condition in evaluation comments below.

If the COVID test is POSITIVE:

- The child remains out of school. Officials from the Albany County Department of Health will contact the family directly and will provide guidance and oversight to the family regarding the child's return to school.

OR

☐ If Parent chooses for their child not to have a COVID -19 test, then the child cannot return to school until:

- It has been ten (10) days since the onset of symptoms AND three (3) days since the last fever without the use of fever-reducing medication AND has
- Documentation of a completed evaluation by the child's medical provider below.

MEDICAL PROVIDER EVALUATION COMMENT(S): DATE OF STUDENT RETURN TO SCHOOL: _____

PROVIDER SIGNATURE: _____ DATE: _____

DATE RECEIVED BY SCHOOL HEALTH OFFICE: _____ SCHOOL NURSE SIGNATURE: _____