COPIAGUE
PUBLIC SCHOOLS

Dr. Kathleen Bannon, Superintendent of Schools
Karen Sheridan, Assistant Superintendent for Student Services

COVID 19 CLEARANCE FORM

DATE: ____________________

STUDENT'S NAME: ____ DATE OF BIRTH: __________________

Dear Parent/Guardian:

Your child was seen in the nurse's office and was sent home due to illness. The following symptoms were noted or reported by your child today, which could be consistent with a COVID 19 infection:

_____ Fever (100.0° or higher) or chills
_____ Cough
_____ Shortness of breath or difficulty breathing
_____ Fatigue
_____ Muscle or body aches
_____ Diarrhea

_____ Headache
_____ New loss of taste or smell
_____ Sore throat
_____ Congestion or runny nose
_____ Nausea or vomiting

RETURN TO SCHOOL GUIDELINES

- If the student has symptoms that could be COVID 19 and wants to return before completing the 10-day home period
  1. At least 10 days have passed since symptoms first appeared **AND;**
  2. The child is free of symptoms **AND;**
  3. At least one day (24 hours) has passed with no fever and without the use of fever-reducing medications

- If the student tested positive for COVID 19
  Individual is assumed to have COVID 19 and must complete the same set of 3 criteria listed above before returning to school

- If the student has symptoms that could be COVID 19 but has not been evaluated by a medical professional or tested for COVID 19
  Medical professional completes this form listing an alternative diagnosis and clearing individual to return to school
  OR
  Medical professional completes this form confirming Negative COVID 19 test and clearing the individual to return to school

COVID 19 TEST: **POSITIVE** ☐ **NEGATIVE** ☐ **NOT PERFORMED** ☐

Diagnosis: ____________________________________ Cleared to return to school on: ______________

Provider Signature: ______________________________ Date: ______________________

Provider Name: ________________________________ Contact Number: ____________________
(Printed)

STAMP: ☐