**HEALTH CARE PROVIDER NOTE: ALTERNATIVE DIAGNOSIS (NOT COVID-19)**

If your child has had any of the symptoms listed below which can be attributed to a diagnosis other than COVID-19, this form must be completed and signed by your child’s healthcare provider (doctor, nurse practitioner, or physician’s assistant) prior to the child’s return to the school building following an absence or being sent home from school:

* Fever/chills (greater than 100.4°)
* Cough
* Shortness of breath/difficulty breathing
* Fatigue
* Muscle/body aches
* Headache
* Loss of taste or smell
* Sore throat
* Congestion/runny nose
* Nausea/vomiting
* Diarrhea

**Parents**, please note: if you choose:

* NOT to have your child examined by a healthcare provider to rule out the cause of fever and/or other symptoms of illness **OR**
* NOT to get your child tested for COVID-19 or if child tests positive

Your child may return to school:

|  |
| --- |
| Student may return to school after: * 24 hours fever-free without the aid of fever reducing medications

**AND** * Symptoms are improving

**AND** * 10 days after symptoms of illness began.
 |
|   |

Child’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade: \_\_\_\_\_\_\_\_\_

Date sent home from school or first day kept home from school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This page to be completed and signed by the child’s healthcare provider.**

❏ I am verifying that the student was found to**have another source of symptoms**. COVID-19 testing was **NOT**done.

❏ I am verifying that the student was found to **have another source of symptoms**. Student had a **NEGATIVE** test for COVID-19.

Student may return to school after:

* They meet regular requirements to return to school for NON-COVID ILLNESS.

Per the above, the earliest the student may return to school is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date)

Healthcare Provider’s name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healthcare Provider’s signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return this complete form to: **[Insert contact information]**