Permission to Return to School

Patient Name: _____ Date of Visit: _____

Date of Test (if applicable): _____ Diagnosis: _____

Date of First Symptoms (if applicable): _____

The following return-to-school guidance aligns with the recommendations of the CDC and VDH and reflects the best possible clinical assessment of a licensed medical provider at the time of service and any applicable test results. This guidance is not a guarantee of any individual's current health status.

☐ Patient tested **POSITIVE** for COVID-19. Patient may return to school 5 days after symptoms started (symptom onset is Day 0), as long as patient has been free of fever for at least 24 hours* and symptoms have resolved. Patient must continue to wear a mask in all public settings for 5 more days. If this is not possible, patient should test negative on Day 6 and again 48 hours later before returning to school. Negative tests must be submitted to school clinic.

☐ *HOUSEHOLD CONTACT NOT ISOLATED*: Patient tested **NEGATIVE** or was **NOT TESTED** but is a household contact of a person known to have COVID-19, is unable to fully isolate from that person, and has not had COVID-19 in the last 90 days. If patient remains asymptomatic, patient may return to school in a mask for 10 days from last exposure to the contagious person (Day 10 of illness).

☐ Patient experienced symptoms that could be related to COVID-19, but tested **NEGATIVE** and does not have any known exposures or ill contacts. Patient does not require quarantine. Patient may return to school when free of fever for 24 hours* and symptoms have improved.

☐ Patient was evaluated according to VDH guidelines for community incidence level of COVID-19. A non-COVID source of symptoms was identified so TESTING WAS NOT INDICATED. Patient can return to school when fever-free for 24 hours* and symptoms have improved.

The patient and/or caregiver have been notified of the test results and have been instructed to follow the guidelines above with regard to school attendance.

Medical Provider Signature: _____MD / DO / NP / PA

Printed Name or Practice Stamp: _____

* without using fever-reducing medicine