St Anthony's High School

COVID Clearance form

Student's Name: ______________________________ Date of Birth: ______________

Date:____________________

Dear Parent / Guardian:

Your child was seen in the nurses' office and was sent home due to illness. Some of the symptoms they exhibited could be consistent with a COVID-19 infection. The items circled below were noted on presentation today:

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- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Your child cannot return to school unless the bottom of this form is filled out, signed, and stamped by your private physician. It must be returned to the school for review and approved prior to sending your child to school.

To be completed by your private Physician:

Date of Examination: ____________ Student's Diagnosis:______________________________

Please fill in / circle all applicable items:

Date of COVID Swab: ______________________ COVID test results: Negative Positive

If COVID Negative: are the symptoms improving AND are they fever-free for at least 24 hours without the use of fever reducing medicines? Yes No.

A COVID swab is not mandatory if the diagnosis of a known chronic condition with unchanged symptoms, or a confirmed acute illness (examples: laboratory-confirmed influenza, strep-throat) AND COVID-19 is not suspected. A note signed by the HCP explaining the alternate diagnosis is required before the student will be allowed to return to school. They may return to school according to the usual guidelines for that diagnosis. Note: a signed HCP note documenting unconfirmed acute illnesses, such as viral upper respiratory illness (URI) or viral gastroenteritis, will not suffice. (Attach documentation to this form)

If COVID-19 positive (Clinically or by swab): are they released from isolation as required by DOH (Significant improvement in symptoms for at least 3 days, at least 10 days since the onset of symptoms have passed, and no fevers for 72 hours off antipyretics)

YES NO

Date:______________ ____________________ Physician Signature ____________________ Physician Stamp