New Garden FRIENDS SCHOOL

This side to be completed by the parent:

Today's Date: _____ Student Name: _____ DOB: _____

Today the student was sent home or stayed at home for the following reason/s:

____experiencing symptom(s) associated with COVID-19, flu or RSV.

Symptoms noted were: _____

____known or possible exposure to a COVID positive person

____other: _____

The student must meet the following criteria before returning to school:

- have a negative PCR COVID test (date of test must be no earlier than Today's Date)
- be fever free without the use of fever-reducing medication for ___24
- have improving symptoms
- feel well enough to attend school
- return a note from your healthcare provider with an alternative diagnosis that explains the symptoms. (Please see side 2 for note to be completed by provider)
- other (as advised by NGFS health team):

  _____

COVID-19 SYMPTOMS*
may include any of the following:

Runny nose or Congestion, a change from baseline
Sore throat
New or worsening headache, a change from baseline
New or worsening cough, a change from baseline
Nausea, Vomiting, Diarrhea
Fever/Chills
Fatigue (extreme)
Muscle aches/body aches
Loss of taste or smell
Shortness of breath or difficulty breathing

Please feel free to contact the school health team at 336-299-0964 or health@ngfs.org with questions.

Completed by_____Relationship to student_____Date_____

BOTH SIDES OF THIS FORM MUST BE COMPLETED

This side to be completed by the Health Care Provider.

Please select <u>all that apply</u> (REQUIRED)

Student was tested for:

_____COVID

_____Flu

_____RSV

_____Strep

_____Other (please list)_____

If student was not tested for COVID, flu and RSV, please list an **alternative diagnosis** that explains the symptoms:_____

_____

_____

Has the student been prescribed an antibiotic? **(REQUIRED)**

____Yes

____No

Student may return to school on _____ (enter date) **(REQUIRED)**

If student regularly experience symptoms due to a known condition or allergy please note those symptoms: here._____

Other notes or recommendations: _____

_____

_____

_____

THIS FORM WILL NOT BE ACCEPTED AND STUDENT MAY NOT RETURN TO SCHOOL IF FORM IS INCOMPLETE.

Provider's Name_____

Provider's Signature: _____

Provider's Name of practice (or office stamp)_____

Provider's Phone Number: _____ Date form completed: _____

BOTH SIDES OF THIS FORM MUST BE COMPLETED