VCSD COVID-19 RETURN TO SCHOOL/WORK FORM

Name:	**DOB:** / /	**Time:**
School:	**Grade:**	**Date of Evaluation:**

Per NYSDOH Healthcare provider (HCP) Evaluation for COVID-19 can be in-person or by video/telephone as determined by HCP

OPTIONAL INFORMATION:

HCP Recommends COVID-19 Diagnostic Test: ___Yes ___ No

Date of COVID-19 Diagnostic Test: ______________________

Results of COVID-19 Diagnostic Test: (check one) Positive ______ Negative _____

****If COVID-19 diagnostic test is positive, 10 days must have passed since resolution of symptoms without using fever-reducing medications prior to resuming gym/sports. Recommend follow up with HCP for athletic participation.***

Alternative Diagnosis: ____

Lab Confirmation of alternative diagnosis: ____

Symptoms to be expected with alternative diagnosis: ____

Expected Length of Alternative Diagnosis: ____

****As per NYSDOH a signed HCP note documenting unconfirmed acute illnesses, such as viral upper respiratory illnesses (URI) or viral gastroenteritis, will not suffice.***

Chronic Condition/Diagnosis: ____

Symptoms Associated with Chronic Condition: ____

Expected length of Chronic Condition: ____

REQUIRED INFORMATION:

Student/Staff may return to school on ____________________ if symptoms are improving AND fever-free for at least 24 hours without the use of fever reducing medications.

Health Care Provider Information: ____

Health Care Provider Signature: ____Date: ___________