ARLINGTON CENTRAL SCHOOL DISTRICT

CLEARANCE TO RETURN TO SCHOOL FORM

School Building & Nurse:_____ Phone: _____Fax: _____

Student Name:_____ Today's Date:_____

The Arlington Central School District, in consultation with the Dutchess County Department of Community and Behavioral Health, requires one of the three conditions below for students that have experienced a COVID-19 symptoms to return to the in person learning environment at school.

1. Documentation from a health care provider following an evaluation. The documentation from a health care provider must include a diagnosis with a condition or illness other than COVID-19 **(and cannot be an unconfirmed acute illness such as a viral upper respiratory illness or viral gastroenteritis)** that is causing the symptoms, the expected duration of the symptoms, and it must indicate if and when the student is clear to return to school**.**

OR

2. Negative COVID-19 diagnostic test result. A negative COVID-19 diagnostic test result must be provided in writing to the school nurse.

OR

3. Symptom resolution. Symptom resolution is defined as at least 10 days from onset of symptoms and the student has no symptoms remaining without using medication for the last 3 days. If you are choosing this option, please fill out the back of this form.

SYMPTOMS - The following symptoms have either been reported or the student is presenting with (list all symptoms):

_____

If you are providing documentation from a health care provider following an evaluation (#1 above), the information below must be completed and submitted to the school nurse prior to returning to the in person learning environment.

Diagnosis:_____

Symptoms:_____

Expected duration of symptoms:_____

The child was (check one) ☐ TESTED ☐ NOT TESTED for COVID-19.

If tested: (circle one) results are : pending positive negative

Date child may return to school:_____

Medical Provider's Name:_____

Date: _____

Physician's Stamp

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11/2/2020

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If you are waiting for symptom resolution (#3 above), the information below must be completed by a parent/guardian and submitted to the school nurse prior to returning to the in person learning environment.

Symptoms:_____

Date Symptoms Began:_____

Date Symptoms Ended:_____

Date Student May Return to the In Person Learning Environment:_____

My child was absent from school because they experienced the symptoms listed above. I am confirming that my child has been home for at least 10 days from the onset of the symptoms and has been symptom free for the last 3 days without the use of medications.

Parent/Guardian Name (Print):_____

Parent/Guardian Signature:_____

Date:_____