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 c Behavioral Health, requires one of the thr symptoms to return to the in person learn	ee conditions below for students		
Documentation from a health care provider must include a diagnosis with a cacute illness such as a viral upper respected duration of the symptoms, and ion	condition or illness other than CO piratory illness or viral gastroe	VID-19 (and cannot be an unc	onfirmed ptoms, the
 Negative COVID-19 diagnostic test res to the school nurse. OR 	ult. A negative COVID-19 diagno	stic test result must be provided	in writing
3. Symptom resolution. Symptom resoluti has no symptoms remaining without using out the back of this form.	•	• •	
SYMPTOMS - The following symptoms has symptoms):	ave either been reported or the s	tudent is presenting with (list all	
If you are providing documentation fro information below must be completed learning environment.			
Diagnosis:			
Symptoms:			
Expected duration of symptoms:			
The child was (check one)	NOT TESTED for COVID-	19.	
If tested: (circle one) results are: pend	ding positive negati	ive	
Date child may return to school:			
Medical Provider's Name:		Physician's Stamp	
Date:			

Revised 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 child has been home for at least 10 days from the onset of the symptoms and has days without the use of medications.	
Parent/Guardian Name (Print):	
Parent/Guardian Signature:	
Data	