KPBSD Return to School After Symptoms Medical Provider Form

Alaska Smart Start 2020-2021 School Year

Student or staff member name: ____
Date seen: ____/___/________ Date of first new symptom onset : ____/___/________
New symptom or symptoms: ____

One or more of these symptoms is on the CDC symptom list for COVID-19: ❑ Yes ❑ No, the patient has no symptoms on the CDC list	**Symptom list:** 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, abdominal pain

The following return to school criteria applies *(check only one)*:

- ❑ The patient had a **negative PCR/molecular test** for COVID-19 since the start of symptoms (not an antigen or antibody test), fever has been resolved for 24 hours and other symptoms have resolved.
  - ❑ Test date: ____/___/________
- ❑ The patient had a **positive test** for COVID-19 and may return 10 days after symptom onset or positive test, whichever happened first, as long as fever has resolved for 24 hours without the use of fever-reducing medications and other symptoms have resolved.
  - ❑ Test date: ____/___/________
- ❑ The patient **did not receive a test** for COVID-19 and may return 10 days after symptom onset as long as fever has been resolved for 24 hours without the use of fever-reducing medications and other symptoms have resolved.
- ❑ The patient was examined and it was determined that the symptoms were not caused by COVID19. The alternate diagnosis is:____________________________________. (This must be filled out, ie, strep throat, etc**. If they are not tested for a definitive diagnosis, they must remain home for 10 days.)** The patient can return to school as long as the symptoms have been resolved for 24 hours without the use of medication. (**Students only: if the cause is a chronic condition, please use the "COVID19 Chronic Symptom Exemption form.")**

The student or staff member may return to school on this date: ____/___/________
(Optional – date may not be able to be determined at this visit.)

Clinician name: ________________________________ Credential: ❑MD/DO ❑PA ❑NP
Clinician signature: _____________________________________
Clinician phone number: (_____)_____-________ Fax number: (_____)_____-________

Revised 9-16-2020