

Your Child Was Seen In the Health Office With Symptoms of COVID-19

Your child _____ is being sent home today ___/___/___ (date of symptom onset) because they have one or more symptoms of COVID-19. Symptoms of COVID-19 are listed* below. Your child has the following symptom(s):

- | | | |
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| <input type="checkbox"/> Fever _____ °F | <input type="checkbox"/> Tired/Fatigue | <input type="checkbox"/> Stuffy nose/congestion |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Muscle / Body aches | <input type="checkbox"/> Runny nose |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Headache | <input type="checkbox"/> Stomachache/Nausea |
| <input type="checkbox"/> Shortness of breath or trouble breathing | <input type="checkbox"/> New loss of taste or smell | <input type="checkbox"/> Throwing up/Vomiting |
| | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Diarrhea |

**This list may not include all possible symptoms. CDC will continue to update this as more is learned about COVID-19.*

Please see the [Symptoms of COVID-19 | CDC](#) for more information.

[NYS Department of Health REQUIRES all school students, teachers, and staff with new or worsening symptoms of COVID-19 not attend school \(excluded\), regardless of COVID-19 vaccination status.](#)

Please Bring This Form to Your Health Care Provider (HCP) Appointment

For your child to return to school they will need to meet one of the following requirements:

Negative COVID-19 Test: proof of the lab result **OR** Health Care Provider (HCP) note indicating lab results are negative (HCP is a Physician, Nurse Practitioner, or Physician Assistant).

HCP Note: must give a diagnosis of a known chronic condition with unchanged symptoms, or a confirmed acute illness (examples: laboratory-confirmed influenza, strep-throat) **AND explain** that COVID-19 is not suspected. Your child may return to school as directed by the HCP for that diagnosis.

Isolation: If your child tests positive for COVID-19, they must stay home and away from others for **5** calendar days, day one begins the day after the positive result. Your child should isolate at home while awaiting test results.

If you choose not to have your child tested, they must stay home and away from others for **5** calendar days beginning the **day after symptom onset** noted above. Symptoms must be improving **AND** your child must be fever-free for 24 hours without the use of fever-reducing medicines in order to return to school.

*In either case above, your child should wear a tight fitting mask for **5 additional days** upon their return to school.

PROJECTED RETURN DATE: _____

According to the CDC, the COVID- 19 signs and symptoms below require immediate emergency care. If you see any symptoms below call 911 or take your child to the closest emergency room.

Difficulty breathing, fast breathing, or trouble breathing at rest	Persistent pain or chest pressure	New confusion	Inability to wake or stay awake	Pale, gray, or bluish lips or face
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Please call your HCP for any other symptoms that are severe or concerning to you.