Cathedral

RETURN TO SCHOOL PASS

Date:_____

Student Name:_____

COVID Test Date:_____(not required)

COVID Results:_____(not required)

The above named student may return to school. He/she **does not** have a COVID-19 related illness.

**Signing this document states that as a medical professional you are agreeing to Cathedral High School's policy that the above student does not have a COVID-19 related illness.
If a student is displaying even one symptom on the CDC list of COVID-19 symptoms, they must be **symptom free** for 24 hours and have either a **NEGATIVE COVID** test or a doctor's note stating it is **NOT A COVID-RELATED ILLNESS**, in order to return to school.

MD/NP/DNP Signature:_____

Medical Office Phone number:_____

The student must check in with the Student Services Office on the day they return to school. The doctor note can either be this form or the doctor's office form. The doctor notes may be emailed to the nurse at mvogt@gocathedral or faxed to her at **(317) 542-1484**. Please call the nurse at **(317) 968-7467** with any questions.