

St. Anne's-Belfield School

RETURN TO SCHOOL/CHILDCARE PLAN

Page 1 of 2: To be completed by **medical provider**

Patient Name: _____

Date of Visit: _____ Date of Exposure (if applicable): _____

Date of Test (if applicable): _____ Date of First Symptoms (if applicable): _____

The following return-to-school guidance aligns with the recommendations of the CDC and VDH and reflects the best possible clinical assessment of the provider at the time of service and any applicable test results. This guidance is not a guarantee of any individual's current health status.

____ Patient tested POSITIVE for COVID-19 and experienced symptoms. Patient may return to school 10 days after symptoms started, as long as patient has been free of fever for at least 24 hours* and symptoms have improved.

____ Patient tested POSITIVE for COVID-19 and has NOT experienced symptoms. Patient can return to school 10 days after the test was taken.

____ Patient was evaluated according to VDH guidelines for community incidence level of COVID-19. A non-COVID source of symptoms was identified so TESTING WAS NOT INDICATED. Patient can return to school when fever-free for 24 hours* and symptoms have improved.

____ Patient experienced symptoms that may be consistent with COVID-19, but was NOT TESTED. Patient may return to school 10 days after the start of symptoms as long as patient has been free of fever for at least 24 hours* and symptoms have improved.

____ Patient tested NEGATIVE or was NOT TESTED, but has been in close contact with a person known to have COVID-19. Patient may return to school 14 days after last contact with the person with COVID-19 as long as no symptoms develop.

____ Patient tested NEGATIVE or was NOT TESTED but is a household contact of a person known to have COVID-19 and is unable to fully isolate from that person. Patient may return to school 14 days after the person with COVID-19 was able to end isolation.

____ Patient experienced symptoms that could be related to COVID-19, but tested NEGATIVE and does not have any known exposures or ill contacts. Patient does not require quarantine. Patient may return to school when free of fever for 24 hours* and symptoms have improved.

The patient/caregiver was notified of the test results and has been instructed to follow the guidelines above with regard to school attendance.

***without using fever-reducing medication**

Signature of Medical Practitioner: _____

Printed Name and Title: _____ MD/DO/NP/PA/RN/LPN

Office Stamp:

St. Anne's-Belfield School

RETURN TO SCHOOL/CHILDCARE PLAN

Page 2 of 2: To be completed by **parent or guardian**

I consent for the Virginia Department of Health/Thomas Jefferson Health District and their staff of case investigators and contact tracers to speak to designated personnel at St. Anne's Belfield regarding any necessary isolation or quarantine procedures related to my child as determined through testing, a case investigation, or contact tracing.

Signature of Parent or Guardian: _____

Printed Name: _____ Date: _____