

BEAVERTON SCHOOL DISTRICT STUDENT RETURN TO SCHOOL FORM

Date

Presenting symptoms

This form should be used for students who have tested positive for COVID-19, are presumed positive for COVID-19, and/or have demonstrated at least one primary COVID-19 symptoms.

يجب استخدام النموذج الخاص به للطلاب الذين ثبتت إصابتهم بـ COVID-19 ويفترض أن نتائج الفحص كانت ايجابية لـ COVID-19، و / أو أظهروا على الأقل أعراضًا أولية لـ COVID-19

The following form should be completed by an Oregon-licensed health care provider (M.D., D.O., N.P. or P.A.), county health official, or BSD District Nurse.

يجب إكمال النموذج التالي بواسطة مقدم رعاية صحية مرخص من ولاية أوريغون (M.D. ، D.O. ، N.P. أو P.A.)، أو مسؤول الصحة بالمقاطعة، أو ممرضة التابعة للقطاع التعليمي في مدينة بيفرتون.

_____ has been evaluated at our clinic.

Patient Name

Date of Birth

Please check one of the following:

- Patient had a **positive COVID-19 test** on _____ (date). Patient should isolate at home until 10 days from when symptoms first appeared on _____ (date of first symptoms) and until fever-free for 24 hours without the use of fever-reducing medication and other symptoms have improved.
- Patient had a **negative COVID-19 test** on _____ (date) and has no known close COVID-19 contacts. Patient may return to school once patient has been fever-free for 24 hours without the use of fever-reducing medication and other symptoms have improved.
- Patient had a **negative COVID-19 test** on _____ (date), but the patient has had close contact with someone who's tested positive for COVID-19. Because of this close contact, there is a chance that the test was a false negative. The patient is being treated as a **presumptive case of COVID-19**. The patient should isolate at home until 10 days from when symptoms first appeared on _____ (date of first symptoms) and until fever-free for 24 hours without the use of fever-reducing medication and other symptoms have improved.
- Patient has not been tested for COVID-19-related symptoms that began on _____ (date). **A clear alternative non-respiratory diagnosis has been identified**; therefore, the patient may return to school once the patient has been fever-free for 24 hours without the use of fever-reducing medication and other symptoms have improved.
- Patient has not been tested for COVID-19-related symptoms that began on _____ (date). **A clear alternative non-respiratory diagnosis has NOT been identified**; therefore, the patient should isolate at home until 10 days from when symptoms first appeared on _____ (date of first symptoms) and until fever-free for 24 hours without the use of fever-reducing medication and other symptoms have improved. **COVID-19 has NOT been ruled out.**

Provider or BSD District Nurse

Date

Provider or BSD District Nurse

Clinic, Center, Hospital, or School

Phone

If the student has NOT been seen by a health care provider, I as a parent/guardian verify that my child has isolated for at least 10 days since the onset of symptoms. In addition, I verify my child has been fever-free for 24 hours without the use of fever-reducing medication and other symptoms have improved.

إذا لم تتم معاينة مقدم الرعاية الصحية للطالب، فأنا بصفتي ولي الأمر/ الوصي، أؤكد من أن طفلي قد تم عزله لمدة 10 أيام على الأقل منذ ظهور الأعراض. بالإضافة إلى ذلك، أؤكد من خلو طفلي من الحمى لمدة 24 ساعة من دون استخدام للأدوية الخافضة للحمى ومن أن الأعراض الأخرى قد تحسنت.

Signature (Parent/Guardian) توقيع ولي الأمر

Date التاريخ