Palos School District 118

COVID-19 Alternative Symptom Certification

Per the IDPH Covid-19 Exclusion Guidance released on August 18, School Districts are instructed to send home or deny entry if ANY of the following symptoms are present: Fever (100.4°F or higher), headache, shortness of breath, cough, sore throat, vomiting, diarrhea, abdominal pain, congestion or runny nose, new loss of sense of taste or smell, nausea, fatigue, muscle or body aches. The return to school guidance for students displaying one of the above symptoms without a negative COVID-19 diagnostic is for students to stay home until symptoms have improved/resolved per return-to-school criteria for diagnosed condition.

For symptomatic students with an alternative diagnosis than COVID-19, please ask your child's physician to complete the form below and return it to: Erin Deval, Director of Student Services at edeval@palos118.org or drop off at District Office at 8800 West 119th Street.

1. **STUDENT INFORMATION**

   Student's Name_____School Name_____

   Date _____ Date of Birth _____

   Completed by: _____

   Grade_____ Parent or Guardian _____

   Home Phone Number_____ Cell Number _____

   Home Address _____

   Parent/Guardian Work Number_____Home E-mail _____

2. **PHYSICIAN INFORMATION (completed by the physician)**

   Physician's Name (Print)_____Physician's License Number _____

   Physician's Specialty (area of practice) _____

   Phone_____Fax_____Physician's E-mail _____

   Hospital(s) Affiliation(s) _____

   Physician's Signature_____Date Signed _____

3. **SYMPTOM INFORMATION (completed by physician)**

   Date of Most Recent Medical Examination _____

   Symptom(s) Student Exhibits_____

   Describe medical condition(s) that causes student to exhibit above listed symptom(s):

   _____

   _____

4. **OTHER INFORMATION, IF APPLICABLE**

_____

_____

_____

5. **RELEASE OF INFORMATION**

I hereby grant my consent to Palos School District 118 to communicate and exchange any and all student record and medical information with the physician listed above in Section 2 of this form. The purpose for this disclosure is educational planning. If I do not grant this consent, the District will not exchange information with the physician, but I will not suffer any other consequences. This consent is valid for one calendar year from the date set forth below, and may be revoked at any time in writing.

6. **SCHOOL NURSE/ADMINISTRATOR INFORMATION (completed by District)**

I _____(print name) reviewed all sections of the Physician Certification, including information from the physician and consider the information to be complete and correct.

School Nurse/Administrator signature _____

SIGNATURE

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____