RETURN TO SCHOOL Instructions for Students

The following Return to School Form shall be given to any student who displays or reports any of the below symptoms of COVID-19 and must be completed by a health care provider before the symptomatic individual can return to school, school-based child care, or extracurricular school activities:

Fever (100°F or higher)	Fatigue
Loss of taste or smell	Chills
Sudden shortness of breath or trouble breathing	Muscle or body aches
Any symptom to a significant degree	Headache
Vomiting	Sore throat
Diarrhea	Congestion or runny nose
Persistent cough	Loss of appetite

If parents/guardians choose to pursue testing without a medical evaluation, the student may return if they receive a negative **PCR** test result, are fever-free for 24 hours, and have not been in close contact with a person known to have COVID-19.

If the parent does not seek testing or a medical evaluation, the student may not return until 10 days after the first day of symptoms and when fever-free for 24 hours without the use of fever-reducing medication.

Please note: A negative rapid or antigen COVID-19 test result cannot be accepted for returning to school due to the rate of false negatives and false positives. **The test must be a PCR.**

RETURN TO SCHOOL FORM

Name of Student: _____ Date of Visit: _____

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

Date of Exposure (if applicable): _____

The following return to school guidance aligns with the recommendations of the CDC and VDH and reflects the best possible clinical assessment by the health care 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 IF 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-19 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 or [ ] **PCR** TEST IS PENDING (check one). Patient may return to school 10 days after the start of symptoms IF patient has been free of fever for at least 24 hours* and symptoms have improved. (Patient may return to school sooner if **PCR** test comes back negative.)

_____ Patient tested [ ] NEGATIVE or was [ ] NOT TESTED (check one), 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 IF no symptoms develop.

_____ Patient tested [ ] NEGATIVE or was [ ] NOT TESTED (check one), 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 is able to end isolation.

_____ Patient experienced symptoms that could be related to COVID-19, but tested NEGATIVE via **PCR** 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. **Negative antigen (rapid) test results are not accepted for return to school.**

_____ Patient was diagnosed with COVID-19 on _____ (within the past 3 months), has fully recovered, is currently asymptomatic, and does not need to quarantine unless new symptoms develop.

_____ Patient received their last dose of COVID-19 vaccine on _____ (> 2 weeks or < 3 months before now), is currently asymptomatic, and does not need to quarantine unless new symptoms develop.

_____ Patient tested NEGATIVE on a COVID-19 **PCR** test and does not have any symptoms, known exposures, or known ill contacts. Testing was done for school/work/travel requirements.

**Without the use of fever-reducing medication*

The patient/caregiver was notified of the test results (if applicable) and has been instructed to follow the guidelines above regarding school attendance.

Provider Signature: _____ Date: _____

Provider Name (printed): _____ MD/DO/NP/PA/RN/LPN

Adapted with permission from form developed by Pediatric Associates, Charlottesville, VA