CCPS HEALTH SERVICES

COVID-19 SYMPTOMS LETTER TO HEALTH CARE PROVIDER

RETURN TO SCHOOL DOCUMENTATION

____ , a CCPS student at________________________________,
(Student Name) (Name of School)

was sent home on __________ due to displaying COVID-19 symptoms.
(Date)
The specific symptoms the student presented with have been initialed below by the school nurse:

Per the MD Department of Health, a COVID-19 symptoms is defined as any one of the following:

_______ Cough
_______ Difficulty breathing
_______ New loss of taste or smell

_______ Fever of 100.4^0 or higher
_______ New onset of severe headache
_______ Sore throat
_______ Diarrhea or vomiting

____________________________________ _____________________/______ _______
(Nurse Name) (Nurse Signature / Initials) (Date)

In order for the student to be allowed to return to school, one of the following criteria must be met:

☐ Documentation of a negative Covid-19 test

☐ Documentation that the student has another specific diagnosis or symptoms are related to a pre-existing condition.

Other specific diagnosis is: ____

OR

A pre-existing condition of:___________________________________ is causing the above symptoms. If these symptoms have not resolved by ______________, the student should return for further evaluation by Health Care Provider.

_____________________________/__________ _________________________/______________
Health Care Provider Signature / Date Printed Name / Phone #

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