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°F 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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