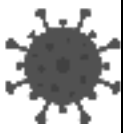
Rev 8/2020

SARS-COV2/ COVID19/ CORONAVIRUS CASE DOCUMENTATION

For individuals Separated, Isolated, or Quarantined due to COVID19 Concerns/Cases/Exposure

LAST NAME, FIRST NAME:	**DOB** ____/_____/_____
AFFILIATION: STUDENT EMPLOYEE RESIDENT VISITOR OTHER	

CLEARANCE TO RETURN FORM ***REQUIRES HEALTH PROVIDER COMPLETION AND SIGNATURE***		**CHECK ONE** ✔
	**CONTINUED PRELIMINARY ASSESSMENT and OBSERVATION** **Presentation:** *Screening 'subtly' triggered and/or low grade Temp Max <100* *No distinct symptoms at presentation* **Criteria Met**: 24 hrs: no fever >100, off anti fever meds, no symptoms developed	
	**CLOSE SURVEILLANCE and CONSERVATIVE SEPARATION** **Presentation**: *Temp>100 and/or symptoms of low suspicion for COVID19* **Criteria Met:** 72 hrs: no fever, off anti fever meds, no new symptoms, symptoms improved **Criteria Met:** 24 hrs: no fever, off anti fever meds, no new symptoms and negative PCR test	
	**ALTERNATIVE DIAGNOSIS** **Presentation**: *Temp>100 and/or symptoms suggestive of non-COVID19 illness* **Criteria Met**: Alternative diagnosis confirmed AND 24 hrs: no fever, off anti fever meds, symptoms improved or resolved in manner consistent with diagnosis Diagnosis: _____Labs/Test:_____ Treatment: _____ Recommendations: _____	
	**COVID DIAGNOSIS and ISOLATION** **Presentation:** *Evaluated and/or diagnosed with COVID19 clinical or laboratory confirmed* **Criteria Met:** 10 days since symptoms began/ 10 days since test positive AND 24 hrs: no fever, off anti fever meds, symptoms improving or resolved Test Date: Test Type: Test Result: Symptom onset date:	
	**COVID EXPOSURE RISK and QUARANTINE** **Presentation:** *Determined to be a close contact or of exposure risk* **Criteria Met**: 14 days since last contact with case AND no symptoms developed Test Date: Test Type: Test Result: Last contact date and time:	

PROVIDER NOTES/COMMENTS:	
PROVIDER TYPE: □ School Health Provider □ Primary Provider □ Urgent Care Provider □ Other	
PROVIDER NAME (print):	Date:
PROVIDER SIGNATURE:	
PROVIDER PHONE: PROVIDER FAX:	
PROVIDER MAY CONTACT SCHOOL HEALTH OFFICE at	