



RETURN TO SCHOOL FORM

The student below is being released back to school and physical education following an:

- ILLNESS (If absent 3 or more day or at nurse's request) ILLNESS (COVID diagnosis) INJURY

Student's Name: _____ DOB: _____

Diagnosis: _____ Date of Diagnosis: _____

Date Symptoms Resolved (If applicable): _____

Criteria to Return Post Covid (Please check below as applies)

- 10 days have passed since symptoms first appeared and symptoms have resolved (No fever (\geq to 100.4 F) for 24 hours without fever reducing medication, improvement of symptoms, (cough, shortness of breath, etc.) OR was asymptomatic for 10 days following positive test.)
- Student was not hospitalized due to COVID-19 infection.
- Cardiac screen negative for myocarditis/myocardial ischemia (All answers below must be no)

Chest pain/tightness with exercise	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Unexplained syncope/near syncope	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Unexplained/excessive dyspnea/fatigue w/exertion	YES <input type="checkbox"/>	NO <input type="checkbox"/>
New palpitations	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Heart murmur on exam	YES <input type="checkbox"/>	NO <input type="checkbox"/>

NOTE: If any cardiac screening question is positive or if student was hospitalized, consider further workup as indicated. May include CXR, Spirometry, PFTs, Chest CT, Cardiology Consult.

- I release the above-named student to return to school and PE following an illness.
- I release the above-named student to return to school and PE following an injury.

Physician's Signature

Date

Please Print Name

Phone Number

Please Print Office Address

Medical Office Stamp



RETURN TO SCHOOL FORM (Continued)

Parent/Legal Custodian Consent:

- I am aware that Dwight Englewood REQUIRES that students that are absent more than 3 days due to illness or injury, must provide a medical release from a Licensed Physician, MD of Osteopathic Medicine, Licensed Physician Assistant, or Licensed Nurse Practitioner before returning to school.
- I acknowledge that the Licensed Health Care Provider listed above has provided medical care to my child.

By signing below, I hereby give my consent for my child to return to school following an illness/injury.

Signature of Parent/Legal Custodian

Date

Please print name and relationship to student