



Deer Park Community City Schools

Deer Park Schools - "Inspiring and Empowering Lifelong Success"

Jay Phillips, Superintendent

Jeff Lewis, Treasurer

Non-COVID Related Illness - Return to School Documentation

Student: _____ **DOB:** _____ was sent home from school on _____

with the following symptoms:

- | | |
|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Rigors (chills with shaking) |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Myalgia (body aches) |
| <input type="checkbox"/> Fever (>100.4 F): _____ | <input type="checkbox"/> Headache |
| | <input type="checkbox"/> Sore Throat |
| | <input type="checkbox"/> Nausea &/or Vomiting |
| | <input type="checkbox"/> Diarrhea |
| | <input type="checkbox"/> Nasal Congestion/ Runny Nose |
| | <input type="checkbox"/> New loss of smell or taste that began on: _____ |

In accordance with guidelines set by Hamilton County Public Health Department, the student is required to self-isolate for 10 days unless he/she/they are evaluated by a physician and it is determined that his/her/their illness is not COVID-19 related and may return to school.

Physician Section (Section A or Section B must be completed by a physician):

Patient: _____ **DOB:** _____ was seen on: _____

SECTION A:

- COVID-19 test recommended.
 - SAR-2-COVID test completed on: _____
 - NEGATIVE** result on: _____
 - If **NEGATIVE** results, please provide an alternative diagnosis for patient's symptoms: _____

SECTION B:

- COVID-19 test NOT recommended. Patient's illness is not COVID-19 related.
 - Please provide a specific diagnosis: _____
 - Student may return to school on: _____

Physician name (print): _____

Date: _____

Physician signature: _____

Phone: _____