**COVID Screening - Nurse Referral**

**Notification/Instructions for Symptomatic Student**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Due to return: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

To the Parent/Guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your child has been screened today by the school nurse and has exhibited at least one of the following symptoms associated with possible COVID-19.

* Temperature 100 degrees Fahrenheit or higher when taken by mouth
* Sore throat
* New uncontrolled cough or cough that causes difficulty breathing (for students with chronic allergic/asthmatic cough, a change in their cough from baseline)
* Diarrhea, vomiting, or abdominal pain
* New onset of headache, especially with a fever
* Loss of taste or smell
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For five (5) calendar days following this notice, your child:

* Will be excluded from the school setting for a minimum of five (5) days due to these possible COVID-19 symptoms from the date of this letter.
* Should remain quarantined at home for 5 days from the first day symptoms appeared AND 24 hours fever-free without fever-reducing medications and with improvement of symptoms. **OR**
* Student can return to school if tested negative for COVID-19 (Rapid and PCR tests are both acceptable) **AND/OR** with a note from the provider stating they believe the patient to have an alternate diagnosis and it’s appropriate for the patient to return to school.

If I can be of further assistance, please feel free to contact me, at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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School Nurse Parent/Guardian Signature