BRIELLE ELEMENTARY SCHOOL

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CHRISTINE CARLSON
Superintendent/
Principal

COLIN SABIA
Vice Principal/
Director of Special Services

DAWN CHERRY
School Business Administrator/
Board Secretary

Student/Staff Name:_____ Symptoms:_____

Date:_____

On the date above, the above student was sent home/ or kept home from school for the above symptoms. Please indicate 1 of the 5 courses of actions below.

Fever is defined as 100.4 and "resolved" means the student has a temperature below that WITHOUT the use of medication for at least 24 hours.

PLEASE BE ADVISED IF TESTING FOR COVID-19: A PCR COVID-19 TEST MUST BE DONE. A RAPID COVID TEST ALONE WILL NOT BE ACCEPTED.

Please select one (per CDC/DOH guidelines):

1.___ Student/Staff had a NEGATIVE test for COVID-19, as well as another source of symptoms, and may return to school 24 hours after fever has resolved and other symptoms are improving.**Please specify diagnosis, if COVID is not suspected.

DIAGNOSIS_____

2.___ Student/Staff NOT found to have another source of symptoms, COVID-19 testing NOT done, patient may return to school 24 hours after fever has resolved and other symptoms improving, with a MINIMUM of 10 days from the onset of symptoms.

3.___ Student/Staff had a POSITIVE test for COVID-19, and must stay home a MINIMUM of 10 days from onset of symptom, be fever free for 24 hours, and other symptoms are improving.

4.___ Student/Staff is asymptomatic but found to have a positive COVID-19. May discontinue isolation and other precautions 10 days after the date of their positive test, unless they become symptomatic during that time. Then they follow COVID symptomatic guidelines (10 days from onset of symptoms 24 hour fever free, and symptoms improving)

5.___ Student/Staff has a known exposure to someone with COVID-19 and must quarantine for 14 days from the date of last exposure regardless of test results. *Date of last exposure _____

The earliest this patient may return to school is:_____
This statement is valid based on relevant information on the date below, but may change based on any new symptoms, exposures, or results. The patient's family has been instructed to notify the office of any changes.

Doctor Signature/Date_____ MD Stamp: