MAMARONECK UNION FREE SCHOOL DISTRICT HEALTH OFFICE
1000 W Boston Post Road
Mamaroneck, New York 10543

RETURN TO SCHOOL MEDICAL CLEARANCE DOCUMENTATION (Completed by Health Care Provider)

Student's Name:________________ **DOB:** ____________ **GRADE:**________ **DATE:** ___________

Date sent home from school or first day absent from school: ______________________________

Date Symptoms First Appeared: ______________

Molecular PCR COVID Test: _______ **Antigen/Rapid Test:** _____

Date of test:___/___/_____________________

Results:
- ◯ Not Done
- ◯ Positive
- ◯ Negative
- ◯ Pending

Please Note that Molecular PCR testing will only be accepted for Clearance to return to school

The **earliest** this patient may return to school is: _______________________________________

Select one per **NYSDOH** guidelines: _____________________________________

_______Student found to have symptoms consistent with COVID. COVID testing was NOT done, student must stay home until 72 hours after fever has resolved and other symptoms have improved, with a MINIMUM of 10 days from the onset of symptoms.

_______Student has a NEGATIVE COVID test and must stay home until 24 hours after fever has resolved and symptoms have improved.

______Student has a POSITIVE COVID test and must stay home until 72 hours after fever has resolved and other symptoms have improved, with a MINIMUM of 10 days from the onset of symptoms.

______Student is asymptomatic but has a POSITIVE COVID test, must stay home for 10 days from the date of the test. If symptoms develop, the student must THEN stay home until 72 hours after fever has improved and other symptoms have improved, with a MINIMUM of 10 days from the onset of symptoms.

______Student has a known exposure to someone with COVID-19 and must quarantine for 14 days from the date of the last exposure, regardless of test results.

_______Student has a PENDING COVID test. No school until student has received results of test or until 72 hours after fever has resolved and other symptoms have improved, with a MINIMUM of 10 days from the onset of symptoms.

Health Care Provider's Name: ______________________________ **STAMP**

Health Care Provider's Signature: _________________________________