CCPS HEALTH SERVICES

COVID-19 LIKE-ILLNESS LETTER TO HEALTH CARE PROVIDER

RETURN TO SCHOOL DOCUMENTATION

_____ , a CCPS student at_____,
(Student Name) (Name of School)

was sent home on _____ due to displaying symptoms of a COVID-19-like illness. The specific
(Date)

symptoms the student presented with have been initialed below by the school nurse:

Per the MD Department of Health, a COVID-19-like illness is defined as:

Any One of the Following	***-OR-***	***At least Two of the following***
_____ Cough		_____ Fever of 100.4^0 or higher (measured or subjective)
_____ Shortness of breath		_____ Chills or shaking chills
_____ Difficulty breathing		_____ Muscle aches
_____ New loss of taste or smell		_____ Headache
		_____ Sore throat
		_____ Nausea or vomiting
		_____ Diarrhea
		_____ Fatigue
		_____ Congestion or runny nose

_____ _____/_____ _____
(Nurse Name) (Nurse Signature / Initials) (Date)

In order for the student to be allowed to return to school, one of the following criteria must be met:

☐ Documentation of a negative Covid-19 test (PCR test, non-rapid)

☐ Documentation that the student has another specific diagnosis or symptoms are related to a pre-existing condition.

Other specific diagnosis is: _____

OR

A pre-existing condition of:_____ is causing the above symptoms. If these symptoms have not resolved by _____, the student should return for further evaluation by Health Care Provider.

_____/_____ _____/_____
Health Care Provider Signature /Date Printed Name /Phone #

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