MILLER PLACE HIGH SCHOOL

15 Memorial Drive ▪ Miller Place ▪ New York ▪ 11764

Health Office Phone: (631) 474-2481
Health Office Fax: (631) 331-4093
Email: mphsnurse@millerplace.k12.ny.us

Date: _____

Dear Parent/Guardian of: _____,

Your child is COVID-19 symptomatic (either sent home from school or based on information that you provided)

- o Fever or chills (Greater than 100° F)

  Temp _____
- o Shortness of breath or difficulty breathing
- o Fatigue
- o Cough
- o Muscle or body aches
- o New loss of taste or smell
- o Sore Throat
- o Headache
- o Congestion or runny nose
- o Nausea
- o Vomiting
- o Diarrhea
- o Other _____

The student will need to be seen by a healthcare provider and can return to school with either of the following:

Copy of all negative COVID-19 test results, including PCR test if done, improved symptoms and must be fever free for at least 24 hours without the use of fever reducing medication.

OR

Documentation from the healthcare provider explaining an alternate diagnosis with clearance to return to school, improved symptoms and must be fever-free for at least 24 hours without the use of fever reducing medications

Please have your healthcare provider complete the attached form.

If you have any questions, please call me at 631-474-2481

Sincerely,

Kimberlee Gelibter, RN

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RETURN TO SCHOOL FORM FOR STUDENTS WITH COVID-19 SYMPTOMS

Student's Name: _____ **DOB:** _____ **Date:** _____

When did symptoms start: _____

Date of COVID-19 Test_____

_____**Not done** (please provide alternate diagnosis below)

_____**Negative Rapid Covid Test**

_____**Negative PCR Covid Test**

If the student receives a negative Rapid test and a sample is sent to a lab for the PCR test, the student must stay home until the PCR result comes back negative too. Please submit copy of all test results to your school nurse.

_____**Positive** (student will need a **Release from Isolation** from the Suffolk County Department of Health)

OR

Alternate Diagnosis: _____

Date student is cleared to Return to School: _____

Student must be fever free without the use of fever reducing medication for 24 hours; no vomiting or diarrhea for 24 hours; if positive for Strep Throat or Conjunctivitis student may not return until they have completed 24 hours of the prescribed antibiotics.

Healthcare provider Stamp

HEALTHCARE PROVIDER'S NAME: _____

PROVIDER'S SIGNATURE: _____