PCP Return to School Form

Date _____

Regarding patient: _____ DOB _____ who is a student at

You are receiving this because the above named patient:

- ❏ Experienced symptoms felt to potentially be COVID 19 related.
- ❏ Reported a known exposure to someone with COVID 19, or a reported a family member is quarantined because of a known exposure
- ❏ Student was asymptomatic but had testing that was positive for SARS-CoV-2 (PCR not antibody testing)
- ❏ Travel ban: Student has traveled to areas currently in the state of CT travel ban.
- ❏ Other

  _____

Decisions regarding return to school must be consistent with DPH guidance and State of Connecticut Executive Orders. Please complete the note below and submit to nurse@ssds-hartford.org so it can be reviewed before the student returns.

Thank you,

Jaime Kramer RN BSN
School nurse

_____
Date

I am the primary care physician for the above named patient and I have evaluated the patient due to the above information. (check all that apply)

- ❏ Based on my evaluation, the patient may return to school on _____(date).
- ❏ Based on my evaluation, the return to school date is TBD
- ❏ Based on my evaluation, the rest of the class has an exposure for which they should quarantine.
- ❏ The following information may be helpful regarding this illness/exposure

  _____

  _____

  ____

_____ _____
Printed name License number

_____ _____
Signature Date

_____ _____
Office Phone Office fax