



Return to School Note when NO Covid-19 TESTING Performed

Student Name _____

Date Sent Home _____

Reason Sent Home _____

I, _____ (print parent/guardian name), verify that:

_____ (child's name)

1. has not had a fever above 100.4 for 3 consecutive days with no medication given
AND
2. that _____ symptoms
have resolved **and** 10 days from start of symptoms has passed.

Known exposure date must be 14 days from _____

Parent Signature _____