



Iditarod Area School District  
 PO Box 90  
 McGrath, AK 99627

**Return to School After Symptoms**

Student or staff member name: \_\_\_\_\_

Date seen: \_\_\_/\_\_\_/\_\_\_\_\_ Date of first new symptom onset: \_\_\_/\_\_\_/\_\_\_\_\_

New symptom or symptoms: \_\_\_\_\_

<p>One or more of these symptoms is on the CDC symptom list for COVID-19:</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No, the patient has no symptoms on the CDC list</p>	<p><b>CDC symptom list:</b>          Fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea</p>
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The following return to school criteria applies (*check only one*):

The patient had a **negative PCR/molecular test** for COVID-19 since the start of symptoms (not an antigen or antibody test), fever has been resolved for 24 hours and other symptoms are resolving

Test date: \_\_\_/\_\_\_/\_\_\_\_\_

The patient had a **positive test** for COVID-19 and will return 10 days after symptom onset or positive test, whichever happened first, as long as fever has resolved for 24 hours without the use of fever-reducing medications and other symptoms are resolving

Test date: \_\_\_/\_\_\_/\_\_\_\_\_

The patient **did not receive a test** for COVID-19 and will return 10 days after symptom onset as long as fever has been resolved for 24 hours without the use of fever-reducing medications and other symptoms are resolving

The patient's symptoms are part of a chronic condition or conditions and they are not contagious at this time. The patient should not be excluded from school for the following symptoms, **as long as they have not worsened:**

\_\_\_\_\_

I will continue to follow this patient for their chronic condition(s)

I do not regularly see this patient and they have been provided with follow-up instructions for their chronic condition(s)

The student or staff member may return to school on this date: \_\_\_/\_\_\_/\_\_\_\_\_

Clinician name: \_\_\_\_\_ Credential: \_\_\_\_\_

Clinician signature: \_\_\_\_\_

Clinician phone number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Fax number: (\_\_\_\_) \_\_\_\_-\_\_\_\_

***Iditarod Area School District Mission Statement***

***The Iditarod Area School District recognizes the unique and distinctive nature of each student with regard to character, capacity, ability and heritage. In doing so, we are committed to providing individualized, comprehensive and sequential programs to all students in an atmosphere which reflects their cultural heritage; and will, through an organized, efficient and effective school program designed and dedicated to incorporating a variety of learning opportunities, assure them of successful achievement as adults in the 21<sup>st</sup> Century.***

***This is our commitment to the students, parents and communities of the Iditarod Area School District. This is our Mission!***