MEDICAL CLEARANCE FOR SCHOOL

PARENTS/GUARDIANS: PLEASE COMPLETE THIS SECTION BEFORE GIVING IT TO YOUR MEDICAL CARE PROVIDER

Student/School Staff Name: ______________________________________

Date of Birth: _______________

School Name: ____

Medical Care Provider:

The above-named individual requires documentation, signed or countersigned by an MD, DO, PA, or NP, that their symptoms are not considered due to COVID-19 and instead represent another clinical entity.

After clinical evaluation, please complete and sign the following:

The above-named individual has been evaluated and:

1. Is not considered to have COVID-19
2. May return to school on ____

MD, DO, PA, or NP Name: ____

Signature: ____

Date: __________________

Phone Number: _____________________