[Insert District Name] Health Office

[ ] Elementary - phonenumber

[ ] Middle School - phonenumber [ ] High School - phonenumber

Name

Grade

Date

Time

Section 1. Completed by School Nurse

Student presented to the health office with the following complaints:

Additional comments or observations:

Does the student have any of the following symptoms:

|  |  |  |
| --- | --- | --- |
| Fever (>100°F) or chills | Yes⬜ | No⬜ |
| Cough | Yes⬜ | No⬜ |
| Shortness of breath or difficulty breathing | Yes⬜ | No⬜ |
| Fatigue | Yes⬜ | No⬜ |
| Muscle or body aches | Yes⬜ | No⬜ |
| Headache | Yes⬜ | No⬜ |
| Loss of taste or smell | Yes⬜ | No⬜ |
| Sore throat | Yes⬜ | No⬜ |
| Congestion or runny nose | Yes⬜ | No⬜ |
| Nausea or vomiting | Yes⬜ | No⬜ |
| Diarrhea | Yes⬜ | No⬜ |
| Temperature: Completed by:  |  |  |

Please have your child’s health care provider fill out Section 2 of this form in order to return to school.