Practice Logo

**SAMPLE Return to School Attestation TEMPLATE**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_**

In response to a positive screening for COVID-19 symptoms on <date of screen>, <Patient Name> was evaluated by the provider signing below on <date of evaluation>.

Category A:

This patient was tested for COVID-19 infection on <date of test>, the results of which are negative.

This patient is cleared to return to school when fever free without fever reducing medications for over 24 hours and symptoms improving.

Category B:

This patient has an alternate diagnosis of <diagnosis> and does not require a COVID-19 test.

This patient is cleared to return to school when fever free without fever reducing medications for over 24 hours and symptoms improving.

Category C:

The patient has a chronic medical condition, <diagnosis>, without new or worsening symptoms and does not require a COVID-19 test.

The patient is cleared for return to school and should have this chronic medical condition noted in their school health form.

Sincerely,

Signature Date

Printed Name of Provider