Midlothian School District 143

COVID-19 Alternative Symptom Certification

Per the IDPH Covid-19 Exclusion Guidance released on August 18, School Districts are instructed to send home or deny entry if ANY of the following symptoms are present: Fever (100.4°F or higher), headache, shortness of breath, cough, sore throat, vomiting, diarrhea, abdominal pain, congestion or runny nose, new loss of sense of taste or smell, nausea, fatigue, muscle or body aches. The return to school guidance for students displaying one of the above symptoms without a negative COVID-19 diagnostic is for students to stay home until symptoms have improved/resolved per return-to-school criteria for diagnosed condition.

For symptomatic students with an alternative diagnosis than COVID-19, please ask your child's physician to complete the form below and return it to the building Principal.

1. Student Information

School Name ______________________ Grade ______________________

Grade ______________________ Date of Birth ______________________

Parent or Guardian ____

Home Phone ______________________ Cell Phone ______________________

Parent/Guardian Work Number ____

Home Address ____

Home Email Address ____

Completed by: ______________________ Date ______________________

2. Physician Information (Completed by Physician)

Physicians Name (Print) ____

Physicians Specialty (area of practice) ____

Hospital Affiliation ____

Physician's Phone ______________________ Fax ______________________

Physician's Email ____

Physician's Signature ______________________ Date ______________________

3. Symptom Information (Completed by Physician)

Date of Most Recent Medical Examination ____

Symptom(s) Student Exhibits ____

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Describe medical condition(s) that cause student to exhibit above listed symptom(s) ______________________

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4. Other Information, If Applicable

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5. Release of Information

I hereby grant my consent to Midlothian School District 143 to communicate and exchange any and all student record and medical information with the physician listed above in Section 2 of this form. The purpose for this disclosure is educational planning. If I do not grant this consent, the District will not exchange information with the physician, but I will not suffer any other consequences. This consent is valid for one calendar year from the date set forth below, and may be revoked at any time in writing.

6. Administrator Information (completed by District)

I ____________________________ (print name) reviewed all sections of the Physician Certification, including information from the physician and consider the information to be complete and correct.

Administrator's Signature ____________________________

Parent/Guardian Name (print) ____________________________

Parent/Guardian Signature ____________________________

Date ____________________________