Corry Area School District
COVID-19 Referral Form

Student Name:_____ Date:_____

Date Symptoms Started: _____

Known Exposure to COVID-19: Yes No

Your child presented to the nurse's office today with symptoms that could be associated with COVID-19. Your child is being sent home from school due to the symptoms circled below:

Cough	Fatigue
Fever or Chills	Diarrhea
Muscle or Body Aches	Headache
New Loss of taste or smell	Sore throat
Congestion or Runny nose	Nausea or vomiting

Shortness of breath or difficulty breathing

These symptoms may indicate an illness that can be spread to others.

Your child may return to school when they meet ONE of the following criteria:

- At least 5 days have passed since symptoms first appeared and at least 24 hours have passed without a fever or the use of fever reducing medications and symptoms are improving; **OR**,
- Student is cleared by a doctor (will need to provide a note from the doctor) and at least 24 hours have passed without a fever or the use of fever reducing medications and symptoms are improving; **OR**,
- Student has a negative COVID-19 test (will need to provide a note from the doctor and a copy of the negative test result) and at least 24 hours have passed without a fever or the use of fever reducing medication and symptoms are improving.

By signing, I acknowledge that I have read and fully understand the criteria for my child to return to school.

Parent Signature: _____

School Nurse Signature: _____