**COVID Return to School Letter Template**

**Child’s (Student’s) Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

◻Student has been seen in the office ◻Student has had a Televisit with provider

* Student has been tested for COVID-19, and is awaiting results *(will remain at home until results are available).*

Date of test: \_\_\_\_\_\_\_\_\_\_\_\_\_

* + Student has been tested for COVID-19 using a molecular test/ PCR, and test results were positive

Date of test: \_\_\_\_\_\_\_\_\_\_\_\_\_

* + Recommendation on return to school:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Student does not require testing for COVID-19 at this time.

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + Student is cleared to return to school on (Date):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + Alternative diagnosis (e.g. chronic disorder) for the mentioned symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Information and/or diagnostic testing:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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This statement is valid based on relevant information on the date below, but may change based on new symptoms, exposures, or results. The patient's family has been instructed to notify the office for any changes. Our office return to school procedures were developed to adhere to the Massachusetts Department of Elementary and Secondary Education protocols and follow the decision tool found at h[ttp://www.doe.mass.edu/covid19/on-desktop/protocols/protocols.docx](http://www.doe.mass.edu/covid19/on-desktop/protocols/protocols.docx) and <https://mcaap.org/2018/wp-content/uploads/new-handout-copy.pages-FINAL-1.pdf>

**Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**