CITY SCHOOL DISTRICT OF NEW ROCHELLE
HEALTH SERVICES DEPARTMENT
515 NORTH AVENUE
NEW ROCHELLE, NEW YORK 10801

Section 2 RETURN TO SCHOOL DOCUMENTATION (to be filled out by health care provider)

Student's Name: _____ Date:_____

COVID Testing (date test taken:_____) **Date of onset of symptoms:** _____

- ❑ Positive (CSDNR accepts positive Rapid Antigen, Rapid PCR, or Conventional PCR test results)
- ❑ Negative (CSDNR **requires** negative Rapid tests results to **be confirmed by Conventional PCR**)
- ❑ Pending
- ❑ Not Done

Please select one, the **earliest** this patient may return to school is: _____

_____ COVID Testing was NOT done, student has an **Alternate Diagnosis:**_____

_____ Student found to have symptoms consistent with COVID. COVID testing was NOT done, student may return to school 72 hours after fever has resolved and other symptoms have resolved, with a MINIMUM of 10 days from the onset of symptoms.

_____ Student has a NEGATIVE COVID test and may return to school 24 hours after fever has resolved and symptoms have resolved.

_____ Student has a POSITIVE COVID test and must stay home until 72 hours after fever has resolved and other symptoms have resolved, with a MINIMUM of 10 days from the onset of symptoms.

_____ Student is asymptomatic but has a POSITIVE COVID test, must stay home for 10 days from the date of the test. If symptoms develop, the student must THEN stay home until 72 hours after fever resolves and other symptoms are resolved, with a MINIMUM of 10 days from the onset of symptoms.

_____ Student has a known exposure to someone with COVID-19 and must quarantine for 10 days from the date of the last exposure. Testing negative for COVID does not shorten the quarantine period.

_____ Student has a PENDING COVID test. No school until the student has received the results of the test. Return to school guidance as above.

Healthcare Provider's Name: _____ **Phone Number:**_____

Healthcare Provider's Signature: _____

Stamp: