Excellence in Education

Plainview-Old Bethpage CSD
Return to School Medical Form

Child's Name _____

Date of Birth _____ **Grade** _____ **Date Seen by Doctor** _____

School _____

Symptoms Similar to COVID-19 _____

_____

Alternate Diagnosis of Acute Illness_____

_____

COVID-19 Testing Recommended? _____ **Yes** _____ **No**

Date Child is Cleared to Return to School _____

Physician Signature / Stamp