Northampton Area School District
Health Services - STUDENT Health Care Provider Form

Student: _____ **Date student sent home:** _____

Recorded Temperature at Health Room Visit: _____

Your child presented to the Health Room with the following **new or worsening** signs/symptoms that would suggest further evaluation for COVID-19 from your doctor:

- ☐ Fever (100.4 or greater)
- ☐ Shortness of Breath
- ☐ Sore Throat
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Headache
- ☐ "COVID Toes"
- ☐ Fatigue
- ☐ Chills
- ☐ Muscle or Body Aches
- ☐ Congestion or Runny Nose
- ☐ Nausea/Vomiting/Diarrhea
- ☐ Abdominal Pain
- ☐ New Loss of Taste or Smell (without congestion)

If you would observe any of the following symptoms, it is a **TRUE EMERGENCY!** CALL 9-1-1 IMMEDIATELY! These include:

- Trouble Breathing
- Persistent pain or pressure in the chest
- New confusion or inability to arouse/awaken
- Bluish lips/face/fingers

Your child may return to school when you can answer "YES" to the following statements:

1. Your medical provider has diagnosed your child with an illness other than COVID-19 and has cleared their return to school (a medical note has been written) **OR**
2. At least 10 days have passed since symptoms began **AND**
3. Student has been **FEVER FREE for 24 hours WITHOUT** taking any fever reducing medication **AND**
4. Symptoms have improved. **(Following Exclusion from and Return to School Requirements)**

The earliest we would expect your student to return to school would be: _____.

The student may return earlier as long as a doctor's release is provided or based on additional recommendations from the COVID Hotline.

Other siblings in the district:_____

Return to School Date: _____

Health Room Nurse: _____ Building: _____

****Please see back of form for Physician Review Information*******

Parent/Guardian - Please have your child's health care provider complete below.

Health Care Provider Review Information

For Health Care Provider: *Please see reverse side for school nurse assessment.*

Findings: _____

Recommendations: _____

Student can return to school on: _____

Restrictions: _____

Health Care Provider Signature _____ MD DO PA CRNP

Date _____

Health Care Provider Name: _____

Phone Number: _____

Parent/Guardian - If your child was not seen in the Health Care Provider's Office, but a phone consult is completed, please have them fax a note containing the above information to the School Nurse.

☐ By checking this box, I give permission for the Health Care Provider to speak with the school nurse should there be any questions in regards to my child's care and/or recovery.

Parent's Signature: _____ **Date:** _____

Parent/Guardian - If you did not contact your health care provider but instead called a COVID Hotline, please fill out below:

☐ Lehigh Valley Hospital COVID Hotline: 1-888-402-LVHN (5846)

☐ St. Luke's Hospital COVID Hotline: 1-866-STLUKES (785-8537) option 7

Please list instructions received: _____

_____

_____

_____

_____

Parent's Signature: _____ **Date:** _____