CLEARANCE TO RETURN TO CAMPUS AFTER ILLNESS

Requires Health Provider Completion and Signature

LAST NAME. FIRST NAME: _____

AFFILIATION: STUDENT EMPLOYEE OTHER **DOB:** ____/_____/_____ **DATE:** ____/_____/_____

DIAGNOSIS

Description: _____Labs/Test:_____

Treatment: _____

CLEARANCE TO RETURN TO SCHOOL		MUST CHECK ONE
	**CONTINUED PRELIMINARY ASSESSMENT and OBSERVATION** **Presentation:** Screening 'subtly' triggered and/or low grade Temp Max <100.4. No distinct COVID19 symptoms at presentation. **Criteria Met**: 24-hours without fever >100.4, off anti-fever meds, no symptoms developed.	
	**NON-COVID DIAGNOSIS** **Presentation**: Temp>100.4 and/or symptoms suggestive of non-COVID-19 illness. **Criteria Met**: Alternative diagnosis confirmed **AND** 24-hours without fever >100.4, off anti-fever meds, symptoms improved or resolved in manner consistent with diagnosis.	
	**CLOSE SURVEILLANCE and CONSERVATIVE SEPARATION** **Presentation**: Temp >100.4 and/or symptoms of low suspicion for COVID-19. **Criteria Met:** 72-hours: no fever, off anti-fever meds, no new symptoms, symptoms improved **OR** 24-hours: no fever, off-anti fever meds, no new symptoms **AND** negative PCR test.	
	**COVID EXPOSURE RISK and QUARANTINE** **Presentation:** Determined to be a close contact or of exposure risk. **Criteria Met**: 14-days since last contact with case **AND** no symptoms developed. **COVID Test**: Date: _____ Test type: _____ Test Result:_____ Last contact date and time:_____	
	**COVID DIAGNOSIS and ISOLATION** **Presentation:** Evaluated and/or diagnosed with COVID-19 clinical or laboratory confirmed. **Criteria Met:** 10 days since symptoms began **AND** 10+ days since test positive **AND** 24-hours: no fever, off anti-fever meds, symptoms resolved **PCR Test***: Date: _____ Confirm PCR (Y/N): _____ Test Result:_____ Last contact date and time:_____ **Onset:** _____ (date) ***Ranney WILL NOT ACCEPT Rapid Screening Tests. PCR test is REQUIRED.**	

ATLETIC CLEARANCE

Clearance for return to athletics? Y/N: _____ Restrictions: _____

Graduated return?_____ Over how many days?_____ Further testing? EKG____ Echo_____ Referral_____

MEDICAL PROVIDER INFORMATION

PROVIDER NAME: _____ **SIGNATURE:**_____

PROVIDER TYPE: ____ Primary Physician ____ Urgent Care Provider ____ Other: _____

PROVIDER CONTACT: Phone: _____ Fax: _____