Susquehanna Valley Central School District

COVID-19 Evaluation Form

Per NYSDOH Healthcare provider (HCP) evaluation for COVID-19 may be in person or by video-telephone as determined by HCP

Name: _____ DOB: _____ TIME: _____

School: _____ Date of Evaluation: _____

**If COVID-19 test is positive, 14 days must have passed since resolution of symptoms without using fever reducing medications prior to resuming gym/sports. Recommend follow up with HCP for athletic participation.*

HCP Recommends COVID-19 Diagnostic Test _____yes _____ no

Date of COVID- 19 Diagnostic Test: _____ Result of COVID-19 Diagnostic test: _____

Alternative Diagnosis: _____

_____

Lab Conformations of Alterative diagnosis_____

Symptoms to be expected with alternative diagnosis: _____

_____

***As per NYSDOH a signed HCP note documenting unconfirmed acute illness, such as viral upper respiratory illness (URI), or viral gastroenteritis will not suffice**

Chronic Condition/Diagnosis: _____

Symptoms Associated with Chronic Condition: _____

_____

Expected length of Chronic Condition: _____

Student/Staff may return to school on _____ , if symptoms are improving AND fever free for at least 24 hours without the use of fever reducing medications.

HCP Signature: _____ Date: _____

Return Completed form to:

Rebecca Flanders RN	Jessica Baker BSN RN	Colleen Lynch BSN RN	Kaethe Mitchell RN
Donnelly Elm.	Brookside Elm	RT Stank Middle	SVHS
60-775-9108	607-669-4105	607-775-9136	607-775-9119
607-775-7507(fax)	607-775-7502(fax)	607-775-7508(fax)	607-775-7509(fax)
rflander@svsabers.org	jbaker@svsabers.org	clynch@svsabers.org	kmitchel@svsabers.org