



WEST SHORE SCHOOL DISTRICT

**Symptomatic Student Return to School  
Verification Form**

*To be completed by Parent/Guardian of a student who was sent home from school with symptoms.*

*Must be returned to school nurse prior to student's return to school.*

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| Student's Last Name | Student's First Name | Grade |
|---------------------|----------------------|-------|
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**Option A:**

I, \_\_\_\_\_ (parent/guardian), attest to the following:

- At least ten (10) days have passed since student's symptom onset; and  
Date of symptom onset: \_\_\_\_\_
- Student has not had a fever for at least twenty-four (24) hours without taking medication to reduce fever during that time; and  
Date of last fever of 100.4 degrees or higher: \_\_\_\_\_
- Student's symptoms, if any, have improved.  
Date symptoms, if any, improved: \_\_\_\_\_
- The Pennsylvania Department of Health did not quarantine student, or a health care provider did not recommend quarantine, for more than 10 days.
- Student does not reside/live with an individual who has tested positive with COVID-19.

**Option B:**

I, \_\_\_\_\_ (parent/guardian), attest that:

- Student's primary health care provider has clinically cleared him/her from a diagnosis of COVID-19 and approved him/her to return to school (attach physician's note); and
- Student does not reside/live with an individual who has tested positive with COVID-19.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_