



CINCINNATI HEALTH DEPARTMENT
SCHOOL AND ADOLESCENT HEALTH PROGRAM

RULE OUT COVID-19 MEDICAL REFERRAL

The school nurse examined your child today and identified the following problem(s) that need medical attention.
This form can be completed by the parent and/or medical provider.

Date:
Dear Parent/Guardian of:
School:
Date of Birth:
Grade/Homeroom:

Your child has been assessed by a Registered Nurse and found to have the following COVID-19 Symptom(s):

Major Symptom(s):

1 Major Symptom requires a COVID test

- Difficulty Breathing
Loss of Taste or Smell
Persistent Cough
Shortness of Breath

Minor Symptoms:

2 minor symptoms require a COVID test or
1 minor symptom if a known exposure to a person with COVID-19

- Fever (T>100.4 F)
Muscle/Body Aches
Diarrhea
Fatigue
Nasal Congestion
Nausea or Vomiting
Headache
Runny Nose
Chills
Sore Throat

Symptom onset date:
Known exposure: Yes No Unknown

Public Health Nurse:
Telephone Number:

CPS accepts any parent/guardian report of a positive COVID-19 test

1. If the proctored COVID-19 home test result was negative:

Your child may return to school when you return the results of the proctored test to the nurse and
Your child's symptoms have improved and
Your child is free of vomiting, diarrhea and/or fever without fever reducing medication for at least 24 hours

2. If your child's COVID-19 test result was positive or if you choose not to have your child tested:
PLEASE REPORT STUDENT POSITIVE TO SCHOOL ATTENDANCE LINE and to the
CINCINNATI HEALTH DEPARTMENT COVID-19 HOTLINE AT 513-357-7462.

Your child should isolate for a minimum of 5 days from the date of symptom onset and/or test date.

Your child may return to school on Day 6 if:

- Your child's symptoms have improved, and
Your child is free of vomiting, diarrhea and/or fever without fever reducing medication for at least 24 hours
Your child should wear a mask on Days 6 through 10 at school.

FOR STUDENTS SEEN BY A MEDICAL PROVIDER: PROVIDER TO COMPLETE BELOW

- The student's COVID-19 test result was: POSITIVE: NEGATIVE:
If not tested or tested negative: Alternative Diagnosis:

Medical Provider Signature: Telephone Number: Date:

Please send completed form back to the school Nurse or fax to: Fax Number 513-357-2811