

Back to School Confirmation Form

Please complete this form to confirm that your child is healthy and able to return to school. By adding your signature, you are verifying that the information is true. Return the completed form to your child's school principal.

Child's Full Name: _____

My child was sent home from or denied entry to school because of an illness that might be COVID-19 on _____ (date - dd/mm/yyyy).

1. I attest that **(INITIAL ONE)**:

_____ My child was previously seen by a doctor or nurse practitioner and was diagnosed with a chronic condition, such as allergies or asthma, with the exact same symptoms my child has now.

_____ My child was experiencing only ONE of these symptoms: sore throat, stuffy nose/runny nose, headache, nausea/vomiting/diarrhea, fatigue/lethargy/muscle aches/malaise. They stayed home yesterday to be monitored and their symptom has improved.

Note: If your child's symptom has not improved in 24 hours or if your child had more than one symptom they need to be tested for COVID-19 or stay home and self-isolate for 10 days.

_____ My child was assessed by a doctor or nurse practitioner on _____ (date). The doctor or nurse practitioner told us that a COVID-19 test was not required and another diagnosis (medical reason) other than COVID-19 explains my child's symptoms (why my child was feeling sick).

_____ My child did NOT have a COVID-19 test but completed 10 days of self-isolation from the date when my child started to feel sick.

_____ My child has received a negative COVID-19 test result after starting to feel sick.

_____ My child has received clearance by Public Health to stop isolating following a positive COVID-19 test result or after being a close contact of someone with COVID-19.

2. I also attest that **(MUST INITIAL ALL)**:

_____ My child has NOT been told by Public Health or a healthcare provider to continue to self-isolate.

_____ My child has NOT had a fever in the last 24 hours (without using medication).

_____ It has been at least 24 hours since my child's symptoms started improving (e.g. only occasional clear mucous from nose; no discharge from eyes; coughing does not interfere with activity; no headache; throat not sore with eating or drinking)

_____ My child has signs they are feeling well (e.g. eating, drinking and sleeping well; normal personality; enough energy for daily activities).

_____ My child has completed and passed the COVID-19 School and Child Care Screening.

Based on all the reasons indicated above, I attest that my child may return to school on:

_____ (date - dd/mm/yyyy).

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

1-866-236-0123
www.healthunit.org



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