Quitman School District
EMPOWERING A PASSION FOR EXCELLENCE

_____ Staff member
_____ Student

COVID-19 Certification to Return to Work/School

This letter is to certify that, _____, has been diagnosed with COVID-19.

I understand that I may not return to Quitman School District until **all** areas of criteria have been met according to my selection above. Please initial next to each statement certifying that the criteria has been met.

Diagnosed with COVID-19 by Positive Test Result

_____ I have been fever free for 24 hours without the aid of fever reducing medication such as Tylenol or Ibuprofen.

_____My symptoms have improved (cough, shortness of breath, etc.).

_____ At least 10-14 (per doctor's order) calendar days have passed since the first onset of symptoms.

_____ I am not under a written order by a healthcare provider to remain quarantined or isolated.

_____ I will submit this certification letter to my building principal/director **upon** returning to work/school.

_____I have attached my doctor's excuse for the days missed.

_____ _____ _____
Parent/Faculty/Staff Signature | Date Signed | Date to Return to Work/School

_____ _____
Principal/Director Signature and Date | School Nurse Signature and Date