



**COVID-19 Return to School/Site Certification Form  
Students and Employees**

THIS FORM MUST BE PROVIDED TO THE PRINCIPAL OR SUPERVISOR  
ADMINISTRATION WILL FORWARD A COPY OF THIS FORM TO THE SAFETY COORDINATOR

**End of isolation for students/employees who exhibited COVID-19 like symptoms: NO medical note/NO test results**

At least 10 days have passed since symptoms first began (or 10 days after test date if asymptomatic) and I have remained fever free (defined as less than 100.4°F) without fever-reducing medications for 24 hours with improving symptoms.

STUDENT NAME \_\_\_\_\_ STUDENT ID # \_\_\_\_\_

SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

RETURN TO SCHOOL DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

By signing this document, I verify to the above statement.

\*\*\*\*\*

EMPLOYEE NAME \_\_\_\_\_ EIN \_\_\_\_\_

SCHOOL \_\_\_\_\_ POSITION \_\_\_\_\_

RETURN TO WORK DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

By signing this document, I certify to the above statement.

**End of quarantine for students/employees who have had close contact with a confirmed COVID-19 positive case**

14 days have passed since the date of my close contact with a COVID-19 positive individual. I have been symptom free and do not have a pending COVID-19 test.

STUDENT NAME \_\_\_\_\_ STUDENT ID # \_\_\_\_\_

SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

DATE OF CONTACT \_\_\_\_\_

RETURN TO SCHOOL DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

By signing this document, I verify to the above statement.

\*\*\*\*\*

EMPLOYEE NAME \_\_\_\_\_ EIN \_\_\_\_\_

SCHOOL \_\_\_\_\_ POSITION \_\_\_\_\_

DATE OF CONTACT \_\_\_\_\_

RETURN TO WORK DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

By signing this document, I certify to the above statement.



**COVID-19 Return to School/Site Certification Form**  
**Students and Employees**  
**POSITIVE TEST RESULTS**

THIS FORM MUST BE PROVIDED TO THE PRINCIPAL OR SUPERVISOR  
ADMINISTRATION WILL FORWARD A COPY OF THIS FORM TO THE SAFETY COORDINATOR

**End of isolation for students/employees who tested positive for COVID-19**

At least 10 days have passed since symptoms first began (or 10 days after test date if asymptomatic) and I have remained fever free (defined as less than 100.4°) without fever-reducing medications for 24 hours with improving symptoms.

STUDENT NAME \_\_\_\_\_ STUDENT ID # \_\_\_\_\_

SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

DATE OF POSITIVE COVID-19 TEST \_\_\_\_\_

RETURN TO SCHOOL DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

By signing this document, I verify to the above statement.

\*\*\*\*\*

EMPLOYEE NAME \_\_\_\_\_ EIN \_\_\_\_\_

SCHOOL \_\_\_\_\_ POSITION \_\_\_\_\_

DATE OF POSITIVE COVID-19 TEST \_\_\_\_\_

RETURN TO WORK DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

By signing this document, I certify to the above statement.