**14823 Path Valley Rd. AN EQUAL RIGHTS AND**

**Willow Hill, PA 17271 OPPORTUNITY AGENCY**

**Phone: 717-349-7172**

**Fax: 717-349-2748**

*Verification Form*

*(To be used for a “Probable Student” and is Returning to School)*

*Step 1: Confirm Student meets definition of a “Probable Student.”* ***To be completed by School District***

* *Was within 6 feet of a Positive Case for 15+ minutes or has had direct contact with infectious secretions of a Positive Case (a “close contact”);*

*AND*

* *Lives with a Positive Case such that Student cannot avoid continued close contact.*

*AND*

* *Is a Symptomatic Student (one symptom from Group A or two symptoms from Group B)*

*Step 2: Complete Return to School Attestation.* ***To be completed by Parent/Guardian***

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

* Student had Close Contact with, *i.e. was within 6 feet for 15 or more minutes with, or had direct contact with infectious secretions of,* a Positive Case; and
* Student lived with a Positive Case and could not avoid continued close contact; and
* The Positive Case’s Isolation ended; and
  + Last Date of Isolation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Student **had**: and
  + One (1) or more of the following symptoms:
    - Cough
    - Shortness of Breath
    - Difficulty Breathing
    - New Olfactory Disease (A loss in the ability to smell or a change in the way odors are perceived)
    - New Taste Disorder (A loss in the ability to taste or a change in the way flavors are perceived)

OR

* + Two (2) or more of the following symptoms;
    - Fever (100.4 or higher)
    - Sore Throat
    - Runny or congested nose
    - Chills or Rigors
    - Myalgia (Muscle pain)
    - Nausea or vomiting
    - Headache
    - Diarrhea
    - Fatigue

Date of Symptom onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* At least fourteen (14) days have passed since Student’s last day of having Close Contact with a Positive Case, which includes fourteen (14) days **after** the Positive Case with whom they live met the criteria to end home isolation; and
  + Date of Exposure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + Date any Positive Case in home ended home isolation: \_\_\_\_\_\_\_\_\_\_\_
* Any or all of following symptoms related to COVID-19 have improved:
  + Fever
  + Chills or Rigor
  + Cough
  + Sore Throat
  + Shortness of Breath
  + Difficulty Breathing
  + Feeling Unusually Weak or Fatigued
  + New Olfactory Disorder (A loss in the ability to smell or a change in the way odors are perceived)
  + New Taste Disorder
  + Myalgia (Muscle pain)
  + Headache
  + Runny Nose or Congestion
  + Diarrhea
  + Nausea or vomiting
  + Fatigue

Student name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today's date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***To be completed by School District***

Date returned to school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_