**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_