



**CERTIFICATION FOR STUDENT RETURNING TO THE SDFAS
CAMPUS AFTER COVID-19 SYMPTOM(S), NEGATIVE/POSITIVE TEST
RESULT, OR EXPOSURE**

(Updated August 31, 2020)

We, the undersigned Parents/Legal Guardians of _____ (“Student”), certify that the following is true and correct (*Please indicate the specific scenario requirement that has been met justifying return to the SDFAS campus by checking the appropriate box below*):

- Symptom(s) and Negative Test.*** Student was PCR tested for COVID-19 after he/she/they began exhibiting symptom(s) consistent with COVID-19 and the PCR test result shows Student is not infected with COVID-19, and the Student has been symptom-free for at least 3 days and a copy of the viral PCR test (i.e. non-antibody) has been shared with the School.

- No Symptoms and Positive Test.*** Student tested positive for COVID-19, but has not had any symptoms associated with COVID-19, and at least 10 days have passed since the test. A copy of the viral PCR test (i.e., non-antibody) test has been shared with the School.

- Symptoms and Positive Test.*** Student tested positive for COVID-19 after having had symptom(s) or having developed symptom(s) after the test. All of the following are true and correct:
 - At least 10 days have passed since Student first began to exhibit symptoms associated with COVID-19, including fever, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea; **AND**

- Student has been free of fever (a “fever” is defined as 100° F [37.8° C] or greater) for at least 24 hours without the use of fever-reducing medicines; **AND**
- Any other symptoms that Student exhibited have improved

“Close Contact” scenario. Student had close contact (was within 6 feet for 15 minutes or more) with a person known to have COVID-19, Student has not had any symptoms associated with COVID-19, and Student has not tested positive for COVID-19, AND it has been 14 days since Student had close contact with that person. A copy of the viral PCR test (i.e., non-antibody) test has been shared with the School.

Symptom(s) Resulting from Chronic Condition. The student’s health care provider (must be a licensed MD/DO/NP/PA who manages that condition) certifies that the Student has a chronic diagnosis that is not related to COVID-19 and has provided a signed note containing the following required information: confirms the chronic diagnosis (i.e., cites labs, date-of record when diagnosed); include provider’s contact information; explain how symptoms are unrelated to COVID-19. A copy of the health care provider’s certification note has been shared with the School.

I understand and agree that if Student exhibits symptoms associated with COVID-19 (e.g., fever, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea) after returning to school, I must inform the School immediately, and the School may direct me to keep Student stay away from School until I meet the School’s requirements in the applicable policy to return to school

Parent/Legal Guardian 1 Name	Signature	Date
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Parent/Legal Guardian 2 Name	Signature	Date
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