Office of the School Nurse

DATE _____

Dear Health Care Provider,

_____ was seen in the school nurse's office. Please evaluate and ask parents to return this form to the school nurse. If you have any questions, please call me at "*insert school phone number".*

Thank you.

_____
School Nurse Signature

HEALTH CARE PROVIDER EVALUATION

S:_____
_____
_____
O:_____
_____
_____
A:_____
_____
_____
P:_____
_____
_____

When may the student return to school?
_____

DODEA Criteria for re-admittance to school:

a. Fever free for 24 hours after school exclusion for temperature 100F or greater
b. No significant nausea, vomiting, or diarrhea for 24 hours
c. Chicken pox (Varicella) lesions crusted and dry, at least 5-7 days from onset
d. Lice treatment initiated
e. Impetigo lesions covered and under care of medical provider
f. Conjunctivitis, signs of infection have cleared
g. Ringworm covered, under care of medical provider
h. Scabies, 8 hours after first prescribed treatment

Any restrictions/limitations for physical education? ☑NO ☐YES (Please explain)

_____

Will Medications be needed during the school day? ☑NO ☐YES

(If yes, please complete the attached form.)

Health Car Provider Signature/Stamp_____ DATE_____