PHYSICIANS CLEARANCE TO RETURN TO CARE

Date:______________________

Dear Health Care Provider,

________________ was sent home from our care on___/___/___with symptoms that could potentially be contagious.

In the best interest of keeping our students and staff healthy we ask that the child does not return to care until he/she has been assessed and cleared of illness by their physician.

This child was sent home with the following symptoms:

- ☐ Fever of ° taken:
  - ☐ under the tongue with Turbo Temp Commercial Thermometer™
  - ☐ under the arm without 1° added with NexTemp™ Clinical Thermometer
  - ☐ pointed at forehead with VeraTemp+™ Professional Non-Contact Thermometer

- ☐ Red or running eyes, colored discharge from the eyes or nose.
- ☐ Cough that is persistent or productive. and/or headache.
- ☐ Sores or crusts on the scalp face or body, including those that are draining.
- ☐ Skin eruptions or rash.
- ☐ Sore throat.
- ☐ Swelling/tenderness of lymph nodes
- ☐ Other:
- ☐ Nausea and vomiting.
- ☐ Pain and stiffness of neck
- ☐ Jaundice symptoms
- ☐ Persistent abdominal pain.
- ☐ Diarrhea.

Thank you,
Your Friends at Masai's Playhouse LLC.

	To be filled out by Doctor:
Date the above named child was seen by Doctor for the above symptoms	
Diagnosis for the above named child (*we are required to confidentially post this to parents of children in our program*)	
Date the above named child is no longer contagious and can return to care	
Special Instructions	

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Physicians Signature

Physician's office stamp