Lincoln-Way Area Special Education
Joint Agreement District #843

601 Willow Street ● Frankfort, IL 60423 ● Phone: (815)806-4600 ● Fax: (815)806-4601

PHYSICIAN'S ALTERNATIVE DIAGNOSIS FORM

To Be Completed by the Physician

Student Name: _____

Date of Birth: _____

In an effort to ensure the health and safety of the school community, any student that demonstrates COVID-like symptoms must provide a note from a qualified medical professional indicating that the symptoms are from an alternative diagnosis or submit negative results of a COVID-19 test before returning to school. In addition, any guidance from the most current *IDPH Return to School Decision Tree for Symptomatic Individuals* will be followed. Recently, the Cooperative has become aware that the student named above was displaying COVID-19 symptoms. The Cooperative may require the information below indicating an alternative diagnosis be provided prior to the student's return to school.

As the treating medical provider please list the alternative diagnosis for the student's COVID-19-like symptoms:

_____

_____

_____

The student's anticipated date of return is: _____. Upon the student's return, the school should be cognizant of the following side effects that may impact the student in the school setting:

_____

_____

Physician's Name: _____ Hospital Affiliation: _____

Address: _____ Telephone: _____ Fax: _____

Physician's Signature: _____ Date: _____