

# 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.

**At this time, a doctor must certify there is no clinical suspicion of COVID in order for the student to return to school. Therefore, we either need a copy of the negative test result or a note (which can be reflected here) with wording as such in order for the child to return.**

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: \_\_\_\_\_