Clearance to Return with Medical Evaluation

At Bright Horizons child care centers, all family and staff households are screened daily for the presence of COVID-like symptoms, including fever, sore throat, difficulty breathing, cough, muscle aches, and new loss of taste or smell. The symptoms are presumed to indicate the presence of COVID-19. The following household has been excluded due to the presence of one or more of these symptoms.

Patient Name:	
Exclusion Date:	

TO BE CLEARED TO RETURN TO THE GROUP CHILDCARE SETTING THE FOLLOWING SPECIFIC REQUIREMENTS MUST BE MET. IF THESE REQUIREMENTS ARE NOT MET, THE HOUSEHOLD WILL CONTINUE TO BE EXCLUDED FOR AT LEAST TEN (10) DAYS.

THESE REQUIREMENTS ARE NECESSARY IN ORDER TO RETURN TO GROUP CARE BECAUSE A SYMPTOMATIC OR POSITIVE CASE IN THE CENTER CAN RESULT IN CLASSROOM/CENTER CLOSURES OF UP TO 14 DAYS.

The individual named above (the "patient") has been under my professional care and has been **medically evaluated**.

Please choose one:

☐ **1. Negative test for SARS-CoV-2**

I have **tested** and diagnosed the patient with a non-COVID illness or condition which causes the symptoms described above.

☐ **2. Positive microbiological test for Non-COVID illness**

I have **tested** and diagnosed the patient with a non-COVID illness or condition which causes the symptoms described above.

☐ **3. Alternate Diagnosis**

ANY ILLNESS PRESENTING CONSISTENT WITH A COLD, FLU, ALLERGIES (IF PREVIOUSLY UNDIAGNOSED), RESPIRATORY INFECTION, EAR, NOSE OR THROAT INFECTION, OR HAND-FOOT-AND-MOUTH DISEASE CANNOT BE CLEARED AS AN ALTERNATE DIAGNOSIS. In these cases, use of option 1 or 2 above is required.

The patient did not present consistent with these listed illnesses and I have diagnosed the patient with a non-COVID illness.

Additional return requirements, only if applicable:

The patient may return to child care/work subject to the following return requirements:

I understand Bright Horizons will rely on my statement to allow the patient to enter and/or attend the child care center.

Medical Provider Name:	***M.D./D.O./N.P./P.A.***
Practice Name:	
Phone Number:	
Signature:	
Date:	

September 2021