Clearance to Return after Exclusion for Symptoms

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 presence of these symptoms is presumed to indicate the presence of COVID-19. The symptomatic household must remain out of the center for an exclusion period of at least ten (10) days, unless the household provides clearance to return from a medical provider.

Patient Name:	
Center Name and Number:	
Exclusion Date:	

FOR USE BY MEDICAL PROVIDER:
The individual named above (the "patient") has been under my professional care and has been medically evaluated.

Please choose one:

☐ **COVID-19 Testing and Resolution of Symptoms**
The patient was symptomatic and tested negative for COVID-19 using a molecular or antigen test for SARS- CoV-2. The patient is cleared to return to child care/work when fever-free for 24 hours (without the use of fever-reducing medicine) and the symptoms have improved.

☐ **Diagnostic Test Required for Acceptable Alternate Diagnosis**
*Diagnostic testing is **REQUIRED** for patients presenting with symptoms of an **UPPER RESPIRATORY INFECTION** or **EAR, NOSE OR THROAT INFECTION.***
I have diagnosed the patient with a non-COVID illness or condition which causes the symptoms described above. The patient was symptomatic and tested (i) positive for a confirmed non-COVID microbiological diagnosis, or (ii) negative for COVID-19 using a molecular or antigen test for SARS- CoV-2.

☐ **Diagnostic Test NOT Required for Acceptable Alternate Diagnosis**
The patient presented with a condition which was not consistent with an upper respiratory infection or an ear, nose or throat infection, and I have diagnosed the patient with a non-COVID illness or condition which causes the symptoms described above.

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:	

February 2021