RIVERHEAD CENTRAL SCHOOL DISTRICT

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Private Physician Participation Statement for Previous COVID-19 Positivity

Declaración de participación de médicos privados para la previa diagnosis de COVID-19 Positivo

The school physician is requiring a medical clearance by private physicians in instances where the parent has noted a previous positive COVID-19 case on the Health History Update. *El médico de la escuela requiere una autorización médica de médicos privados en los casos en que el padre haya notado un caso COVID-19 positivo anterior en la Actualización del historial de salud.*

Please print this form, have your child's physician sign/stamp it and then return it to the school nurse in your child's building. *Imprima este formulario, pídale al médico de su hijo que lo firme/selle y luego devuélvalo a la enfermera de la escuela en el edificio de su hijo.*

Student Name: _____
Nombre del Estudiante

Student Date of Birth: _____
Fecha de Nacimiento

Student ID#: _____
 # de Identificación

[ ] **I am aware of this child's medical history of being COVID-19 positive and this child is clear for full participation in sports..**

Medical Provider Signature: _____ Date: _____

Physician Name *(please print)*: _____

Physician Address: _____

_____

Physician Phone: _____

Physician Stamp: