

**RETURN TO SCHOOL NOTE FOR
INFLUENZA (FLU) LIKE ILLNESS
2009-2010 PANDEMIC PERIOD**

Date: _____

Student's Name: _____ Grade: _____

My child had been fever free for 24 hours without the use of any medication that has fever reducing ingredients and illness symptoms are dramatically improved (many medications may contain fever reducing ingredients such as ibuprofen and acetaminophen please read the label and consult with your health care provider or pharmacist if you have any questions).

Initial Date of Illness (if available): _____

Date and time of **last** documented temperature over 100F:

Date: _____ Time: _____

Has your child been evaluated and cleared by your physician to return to school? (If yes, please attach Dr. note)

Yes _____ Not seen _____

Name of parent/guardian: _____

Signature: _____ Date: _____

Contact Information: _____

SCHOOL NURSE REVIEW:

_____ Approved to return to school

Return Date: _____

_____ Denied request to return to school

Reason _____

School Nurse Name: _____ Date: _____

School Nurse Signature: _____