ANIMAS HIGH SCHOOL
DURANGO COLORADO

Physician Declaration of Chronic Illness/Alternative Diagnosis to COVID

This document must be completed by a physician with prescriptive authority licensed to make medical diagnoses.

This form is to be used for Students/Staff that have symptoms that are "covidLike", but have been determined to be due to a Chronic Illness OR are routine occurrences for this student or staff member.

First and Last Name: _____ **Grade(for students):**_____

Physician Confirmation Section: Required to be Completed by the Physician

Please list this student/staff member's symptoms that occur due to their chronic illness OR are routine occurrences for this student/staff member:

DIAGNOSIS (ES)	SYMPTOMS

Further Explanation: _____

_____

_____

This student/staff member is permitted to be on campus without restriction IF and when they are experiencing any of the above listed symptoms that are "covid like", but have been determined to be due to other causes.

****IF this student/staff member experiences any of the following "major" covid symptoms including:**_____

_____

_____

in addition to their routine symptoms, then they are NOT permitted to be on campus and should follow the recommended protocols for those with COVID Symptoms and notify the school and their physician as soon as possible.

Physician's Full Name: _____

Physician's Office Phone Number:_____

_____ _____

Physician Signature **Date**