State of New Jersey
DEPARTMENT OF EDUCATION
PASSAIC COUNTY OFFICE

RETURN TO SCHOOL NOTE FOR INFLUENZA (FLU) LIKE ILLNESS

Public Health
PASSAIC COUNTY
DEPARTMENT OF HEALTH

Date: _____

Student's Name: _____ Grade: _____

My child has been fever free for 24 hours without the use of **any** medication that has fever reducing ingredients (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 100°F:
Date: _____
Time: _____

Date and time of **last** dose of any medication with fever reducing ingredients:
Date: _____
Time: _____

Name of parent/guardian: _____

Signature: _____ Date: _____

Contact Information: _____

Do Not Write Below This Line

School Nurse Review:

_____ Approved for return to school Return Date: _____

_____ Denied request to return to school Reason: _____

_____

School Nurse Name: _____ Date: _____

School Nurse Signature: _____