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Seymour J. Abrams

Cheder Lubavitch Hebrew Day School

A School for Progressive Elementary Education

No Clinical Suspicion of COVID-19

Dear School Nurse or Administrator,

PCP Name: ____

Patient Name: ____

Patient has the following symptoms: (please check all that apply)

- ❒ Fever or chills
- ❒ Cough
- ❒ Shortness of breath or difficulty breathing
- ❒ Fatigue
- ❒ Muscle or body aches
- ❒ Headache
- ❒ New loss of taste or smell
- ❒ Sore throat
- ❒ Congestion or runny nose
- ❒ Nausea or vomiting
- ❒ Diarrhea

Alternative diagnosis to COVID-19:

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Comments:

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Physician Signature: __________________________________ Date: _____________

Physician Stamp/Seal:

Fax this form to: 847-674-6095

Or email it to covid@clhds.com