



State of New
Jersey
DEPARTMENT OF EDUCATION

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

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.) ****It's important to note that not everyone with the flu will have a fever. My child has been free of symptoms of the flu for a minimum of 24 hours, i.e. cough, sore throat, runny or stuffy nose, headache, vomiting or diarrhea.**

- Initial Date of Illness (if available): _____
- Initial Symptoms Noticed: _____
- 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: _____
- Evaluated by Pediatrician Yes No
 - Doctor's Note Attached

Name of Parent/Guardian: _____

Signature: _____ Date: _____

Phone #'s: _____

School Nurse Review

_____ Approved for return to school
Return Date: _____

_____ Denied request to return to school
Reason: _____

School Nurse Name: _____ Date: _____

School Nurse Signature: _____