



State of New Jersey
 DEPARTMENT OF EDUCATION
 SUSSEX COUNTY OFFICE



SUSSEX COUNTY
 DEPARTMENT OF ENVIRONMENTAL
 AND PUBLIC HEALTH SERVICES

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.)

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: _____

School Nurse Review:

_____ Approved for return to school

Return Date: _____

_____ Denied request to return to school

Reason: _____

School Nurse Name: _____ Date: ___/___/___

School Nurse Signature: _____