Sayreville Public Schools
Health and Nursing Services
P.O. Box 997
Sayreville, New Jersey 08871
Phone: 732-525-5200

School Nurse	
Arleth	Ext. 4100
Eisenhower	Ext. 3100
Truman	Ext. 2100
Wilson	Ext. 1100
Project Before	Ext. 1433

Superintendent: Dr. Richard Labbe
District Physician: Matthew J. Speesler M.D.
Nursing Supervisor: Ms. Carolynn O'Connor
Athletic Director: Ms. Jennifer Badami

School Nurse	
Samsel UES	Ext. 6100
Middle School	Ext. 7100
High School	Ext. 8100
Athletic Trainer	Ext. 8322

Rev. 02-08-21

Infectious or Contagious Illness or Disease Clearance Form

Attention School Health Official

I have evaluated _____, on _____ at which time
Patient's Name Date
_____ was free of any contagious or infectious illness or disease and is
Patient's Name
cleared to return to school on _____. Patient has completed/will complete all
Date
CDC and New Jersey DOH recommended quarantine or isolation periods on _____.
Date

____ Patient tested positive for SARS-COV2/COVID-19 _____
Date

____ Patient tested negative for SARS-COV2/COVID-19 _____
Date

____ Patient was symptomatic of SARS-COV2/COVID-19 but was not tested.

____ Patient was presumed positive for SARS-COV2/COVID-19 but was not tested.

____ Patient was diagnosed with an infectious/contagious illness or disease other than SARS-COV2/COVID-19. Please specify illness or disease _____

____ Anticipated follow up with doctor before _____
Date

Additional Information: _____

Restrictions: _____

Recommended Accommodations: _____

_____ Patient is involved in school athletic _____ Patient is involved in school extracurricular program
_____ Patient has been evaluated and is **NOT** cleared to return to school athletics/extracurriculars
_____ Patient has been evaluated and is cleared to return to school athletics/extracurriculars **WITHOUT** restrictions
_____ Patient has been evaluated and is cleared to return to school athletics/extracurriculars **WITH** restrictions listed below:
_____
_____
_____
_____
Physician Follow-up date if applicable _____

Physician's Name: _____ Date: _____

Physician's Signature: _____

Physician's Office Address: _____

Physician/Provider's Stamp: