

Return to School Declination After Positive COVID 19 Test

Please print or type:

Name: \_\_\_\_\_ CWID: \_\_\_\_\_

Contact e-mail: \_\_\_\_\_

Contact Phone: \_\_\_\_\_

Date of Positive Test: \_\_\_\_\_

Date completing Form: \_\_\_\_\_

Date of return or Arrival on campus: \_\_\_\_\_

Form must be completed 10 days or more AFTER testing positive for COVID 19. You must upload a this completed form along with your positive COVID test results at the same time.

Initial: \_\_\_\_\_ I have not had a fever (Temperature greater than 100 degrees Fahrenheit) for at least 24 hours without the use of fever-reducing medication

Initial: \_\_\_\_\_ I have been COVID symptom free for at least 24 hours or more, symptoms may include Nausea, vomiting, diarrhea, Shortness of breath (resting and exertion), fever, cough, loss of taste and smell

*I certify the above facts are true. I understand that UA staff may verify the accuracy of the above information. Furthermore, I understand I subject myself to disciplinary action in the event the above facts are found to be false.*

Student Signature: \_\_\_\_\_

Date signed: \_\_\_\_\_