Fall 20___

Spring 20___

Summer 20___

UNIVERSITY *of* HAWAIʻI®
SYSTEM

Confirmation of Recent COVID-19 Infection

(for ***Fully Vaccinated*** students)

In order to be eligible to return to campus after being diagnosed with a recent COVID-19 infection you must complete this form and submit this and the following to your campus Covid-19 Response team (you can find a list here: https://www.hawaii.edu/covid19/covid-19-info-by-campuses/) via UH File Drop (https://www.hawaii.edu/filedrop/) services.

1. Provide a copy of initial positive COVID-19 test result or a letter from a medical provider documenting test result and/or onset of illness date.
2. Letter from medical provider with date of release from isolation and clearance to return to campus.

All documents must be on official medical provider-issued letterhead and submitted with this form for processing. Please allow a week for processing.

SECTION A: ***To be completed by student (and/or legal parent/guardian)***

Student's Name: ____ UH ID/Username: ____________________

Phone: _______________ UH Email Address:______________________ UH Home Campus: ____________

I am also a University of Hawaii faculty/staff member.

By signing below: I understand that as I have recently (within the last 90 days) tested positive for COVID-19, I may not return to campus or attend any in-person activities until I am officially cleared by my medical provider and should isolate for the recommended duration as advised by my medical provider. I further understand that once cleared by my medical provider, I must continue to comply with University rules and regulations pertaining to COVID-19.

Student's Signature: ____ Date: ________________

Parent/Guardian Name: ____ Date: ________________
[if student is <18 years]
Parent/Guardian Signature: ____

SECTION B: ***To be completed by Healthcare Professional ONLY (MD, DO, APRN-Rx, PA)***

Date of positive laboratory-confirmed (RT-PCR or antigen) COVID-19 infection:____________________(Date)

Student is/was cleared to return to campus *[after their required 10 day isolation and without fever for 24 hours and resolution of symptoms*] on: ______________________(Date)

______________________________	___________________________________	_______________________
Healthcare Professional Name/Title (print)	Healthcare Professional Signature	Date

Address:____ License Number:__________________

For Office Use Only:
Effective Term: ________________ Processed By: __________________________ Processed Date: _____________