Pleasant Valley School District

Please contact your building principal or direct supervisor

Temporary Exclusion Notice for PVSD STAFF

Date: _____

Employee Name: _____

You are being sent home from work due to the complaint of the following symptoms that may indicate a respiratory viral infection such as COVID-19.

Following guidelines from the Pennsylvania Department of Health, it is recommended you are evaluated by your physician.

For the health and welfare of you and the safety of others, you will be temporarily excluded from work examined by a healthcare provider and have been medically approved to return to work as indicated by your healthcare provider's completion of this form.

The following recommendations are guidance from the Pennsylvania Department of Health, CDC, and Pennsylvania Department of Education:

1.) For staff, who are not currently a close contact or quarantined, presenting with symptoms associated with COVID-19 may return to work when any one of the following applies:

a.) Symptomatic and not tested: exclude for 10 days from symptom onset AND at least 24 hours fever free (if present) AND improved symptoms; or

b.) Symptomatic and medically cleared by Health Care Provider: exclude until fever free for 24 hours (if fever present) and symptoms improving; or

c.) Symptomatic with test negative: excluded until fever free for 24 hours (if fever present) AND symptoms improved.

1.) If you are considered a close contact, you will be excluded for 10 days from the last known exposure, and are required to monitor for any onset of symptoms. The quarantine can end after day 10 if no symptoms have been noted. (Please see Symptom Monitoring Tool) Please continue to self-monitor for symptoms until day 14.

a.) If a negative test is obtained on or after day 5 of the quarantine period, and you remain symptom free, the quarantine can end on day 7 with a note provided from your doctor but no sooner.

b.) The Pennsylvania Department of Health Guidelines state that the safest quarantine time is 14 days.

c.) Please provide documentation from either the Pennsylvania Department of Health or your physician for return to work.

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******Please have Physician complete the Health Care Provider Information form******

For Health Care Provider

Employee Name:_____

Findings:

_____

Recommendations:

_____

Employee can return to work on: _____

Restrictions:

_____

Health Care Provider Signature _____ MD DO PA CRNP

Date _____

Health Care Provider Name:

_____

Phone Number: _____

Please Note*** If you were not seen in the Health Care Provider's Office, but had a phone consult or a virtual visit with a health care provider, please have them fax a note containing the above information to the School Nurse.

☐ By checking this box, I give permission for the Health Care Provider to speak with the school nurse should there be any questions in regards to my care and/or recovery.

Employee's Signature: _____ Date: _____