Pleasant Valley School District

Nurse contact #: 570-402-1000

PVE ext. 6061, PVI ext. 3104, PVMS ext. 2062, PVHS ext. 4061

Temporary Exclusion Notice-STUDENT

Date: _____

Dear Parent or Guardian of _____ :

Your child is being sent home from school because he/she is complaining of symptoms that may indicate a respiratory viral infection such as COVID-19. The symptoms your child is reporting include the following:

_____

_____

For the health and welfare of your child and the safety of others, your child <u>will be excluded from school</u> until he/she is examined by a healthcare provider and is medically approved to return to school upon completion of the <u>Health Care Provider Information</u> Form.

***If your child has a COVID-19 positive test or has been in close contact to person with Covid-19 please follow Pennsylvania Department of Health guidance and recommendations. Your child will be required to stay home from school for minimum of 10 days, fever free for at least 24 hours without the use of fever-reducing medications, and improved symptoms.**

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

- **Symptomatic student not tested : exclude for 10 days from symptom onset AND at least 24 hours fever free (if present) AND improved symptoms; or**
- **Symptomatic student medically cleared by Health Care Provider: exclude until fever free for 24 hours (if fever present) and symptoms improving; or**
- **Symptomatic student with test negative: excluded until fever free for 24 hours (if fever present) AND symptoms improved.**

(Following Exclusion From and Return to School Requirements)

******Please have Physician complete the <u>Health Care Provider Information</u> form******

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For Health Care Provider

Findings:

_____

Recommendations:

_____

Student can return to school on: _____

Restrictions:

_____

Health Care Provider Signature _____ MD DO PA CRNP

Date _____

Health Care Provider Name:

_____

Phone Number: _____

Parent/Guardian - If your child was 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 child's care and/or recovery.

Parent's Signature: _____ Date: _____