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.

- If you have a COVID-19 test and the result is positive, you must stay home from work for 10 days minimum and return to work when at least 24 hours have passed since last fever without the use of fever-reducing medications and improvement in symptoms or have had two negative viral tests spaced 24 hours apart.

- If you have a COVID-19 test and the result is negative, you must stay home until experiencing an improvement in symptoms. Consider another test if symptoms worsen.

- If it is medically confirmed that you have a non-COVID-19 illness, please have your healthcare provider complete this form and turn in upon return to work.

(Following Exclusion From and Return to School Requirements)

Pleasant Valley School District

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Temporary Exclusion Notice for PVSD STAFF

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

For Health Care Provider

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:** _____