

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.

- 1.) If you have a COVID-19 test and the result is positive, you must contact the Department of Health and follow the guidelines recommended to you.
- 2.) If you have a COVID-19 test and the result is positive, you must stay home from work for 10 days minimum and follow the Pennsylvania Department of Health guidelines.
- 3.) 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.
- 4.) 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.

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Temporary Exclusion Notice for PVSD STAFF

(Following Exclusion From and Return to School Requirements)

******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 Supervisor/Administration.

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

Employee's Signature: _____ Date: _____