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:

____

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

1.) 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.

    a.) If you are considered a close contact, you will be excluded for 14 days from the last known exposure, and are required to monitor for any onset of symptoms. The entire 14 day quarantine must be completed even if you have a negative test result during the 14 day period.

    b.) Please provide documentation from either the Pennsylvania Department of Health or your physician for return to in-school learning.

2.) 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:

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

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

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

3.) Close contacts/siblings of those who are pending test results or have been sent home with symptoms consistent with COVID-19, can continue normal activities and remain in school until test results are available as long as the close contacts are not exhibiting any symptoms.

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(Following Exclusion From and Return to School Requirements)

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

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: __________