

PALMERTON AREA SCHOOL DISTRICT

Health Services- EMPLOYEE Health Provider Form

Employee: _____

Date employee sent home: _____

Recorded temperature at Health Room Visit: _____

Per the Department of Health and the Department of Education, children are to be sent home if they have one or more of the following symptoms. Your child presented to the Health Room today with the following new or worsening signs/symptoms that would require further evaluation for COVID-19 from your primary healthcare provider:

Fever (100.0 or higher)

Sore throat

Cough

Chills

Shortness of breath or trouble breathing

Muscle pain

Diarrhea

Headache

Lack of smell or taste

Congestion or runny nose

(not attributed to nasal congestion)

Fatigue

If you would observe any of the following symptoms, it is a TRUE EMERGENCY! Call 911 IMMEDIATELY! These include:

Difficulty Breathing

Bluish lips/face/ fingers

Persistent pain or pressure in the chest

New confusion or inability to arouse or awaken

****Please contact your healthcare provider for a release to return to school.**

****Please see back of form for Healthcare Provider Review Information**

Employee- Please have your healthcare provider complete below.

Healthcare Provider Review Information

Please see reverse side for school nurse assessment.

Findings: _____

Recommendations: _____

Employee can return to school on: _____

Restrictions: _____

Healthcare Provider Signature: _____

Date: _____

Healthcare Provider Name: _____

Phone Number: _____

Employee: If you were not seen in the healthcare provider's office, but a phone/video consult was completed, please have them fax a note containing the above information to the school nurse. The fax number is _____

By signing below, I give permission for my healthcare provider to speak with the school nurse should there be any questions in regards to my care and/or recovery.

Employee Signature: _____ Date: _____