

## AFFIRMATION OF INTENT TO COMPLY WITH TEST AND STAY REQUIREMENTS

Student/Staff Name: \_\_\_\_\_ Contact Date: \_\_\_\_\_

You are receiving this form because the person listed above has been identified as a close contact of a COVID-19 case that occurred during the school day, they have not had any other contact with a known COVID-19 case outside of school, they are unvaccinated or only partially vaccinated, and they are being given the option to continue with in-person learning or work instead of observing normal school quarantine procedures at home. If the person has had other contact with a case outside of school or is fully vaccinated, please contact the school for further instructions.

By initialing/signing this form and providing it to the school, you are indicating that you wish to have the person listed above continue participating with in-person learning or work despite being identified as a close contact of a COVID-19 case and that you agree with the following statements (please initial each statement):

- \_\_\_ I **understand the requirements** for the person listed above to continue with in-person learning or work instead of quarantining at home.
- \_\_\_ I understand that *Test and Stay* applies **only to in-person learning or work** and that the person listed above must continue to quarantine away from public/team athletic/social activities and follow normal quarantine procedures for other activities (e.g., team sports, extracurricular activities, gatherings with individuals outside of their household, etc.).
- \_\_\_ I (or another adult) will perform a daily symptom assessment of the person listed above each morning at home **prior to the person boarding a school bus or otherwise reporting to school** for a full **10 calendar days** from the Contact Date listed above.
- \_\_\_ The person listed above will **quarantine at home and not report to the school**, and I will contact the school if they experience any of the COVID-19 symptoms listed below at any time during the 10 day cycle.

- Fever (100.4 or higher) or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

\_\_\_\_\_  
Staff/Parent/Guardian Signature

\_\_\_\_\_  
Contact Number

\_\_\_\_\_  
Date

## DAILY SYMPTOM SCREENING CHECKLIST FOR FAMILIES

Individuals or families participating in *Test and Stay* should keep this checklist handy to guide your at-home daily symptom check. If the individual participating in *Test and Stay* experiences **any of these symptoms or answers 'YES' to the questions** at any time during their monitoring period, they should not report for in-person learning or other in-person school activity, and the staff person, or the student's parent or guardian, should contact the school for further instructions.

What date has the school told you to perform daily screening until? \_\_\_\_\_

Has the person experienced any of the following symptoms in the past 24-hours?

SYMPTOM	YES	NO
Elevated temperature ( $\geq 100.4^{\circ}\text{F}$ )	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>
Frequent coughing	<input type="checkbox"/>	<input type="checkbox"/>
Trouble breathing	<input type="checkbox"/>	<input type="checkbox"/>
Unusually tired	<input type="checkbox"/>	<input type="checkbox"/>
Muscle or body aches	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Trouble tasting or smelling	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Stuffy or runny nose	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>

Has the person been in close contact with any other individual outside of the school known to have COVID-19 in the past 24-hours?

YES  NO

Has the person been instructed by local health officials to quarantine or isolate within the past 24-hours?

YES  NO

***If the answers to any of these symptoms or questions is "YES", stay at home and notify the school.***

## TEST AND STAY DECISION WORKSHEET

Once a person is identified as a close contact of a COVID-19 case, HPSD will use this worksheet to determine if that student or staff person (i.e., the *Contact*) should be given the option to participate in the *Test and Stay* protocol or if they should follow normal quarantine procedures.

1. Did the *Contact* have any exposure to any COVID-19 case outside of the normal school day?

NO

↓  
Move to Q2

YES →

**STOP!**  
Follow normal  
procedures

2. Is the *Contact* able to continue to consistently wear a mask at all times (or can they be afforded alternative mitigation strategies) while inside the facility and have a parent/guardian screen them (or screen themselves if they are an adult) for COVID-19 symptoms prior to leaving their home every day for 5-7 calendar days?

YES

↓  
Move to Q3

NO →

**STOP!**  
Follow normal  
procedures

3. Can we restrict participation in, and provide appropriate alternatives to, higher-risk (droplet generating) activities, such as those involving singing, wind instrument playing, and aerobic Physical Education activities, for the *Contact* for 5-7 calendar days?

YES

↓

Test and Stay is appropriate.

NO →

**STOP!**  
Follow normal  
procedures