

ARGYLE CENTRAL SCHOOL DISTRICT

“Test to Stay” Permission Form

Student Name _____ **Date of Birth** _____

Your child has been exposed to an individual who has tested positive for COVID. Your child is eligible to participate in the “Test to Stay” program.

In order for your child to be allowed to participate, please complete this permission form and return it to the school nurse. Please read all attachments carefully.

I have read and understand the following:

- My child has not been fully vaccinated.
- His/her exposure(s) occurred while at school or during bus transportation to or from instruction.
- The COVID positive individual and the exposed student (your child) must have consistently and correctly wearing well-fitting masks during the exposure.
- The exposed student has not developed any signs or symptoms of COVID-19 since their exposure.
- Participants in the TTS program will wear well-fitting masks in school at all times, other than when eating or drinking.
- Participants will adhere to the testing schedule developed by the district
 - At home tests do not qualify for this protocol.
- As a parent/guardian I agree to:
 - Allow the district to report all test results to NYS DOH laboratory system
 - Conduct active monitoring (explicitly asking the student about signs and symptoms of COVID-19) each day before and after school
 - Immediately contact the child’s healthcare provider and the school nurse if any signs or symptoms develop.
 - Refrain from sending the participating student to school if any signs or symptoms develop in the child or anyone in the home and call the school nurse to report the symptoms.
 - Promptly pick up their child from school, should they test positive or develop signs or symptoms of COVID-19 during school instruction.
 - Keep the student at the location specified in their quarantine order when not attending in-school instruction.

Parent Name (Print)

Parent Signature

Date _____