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SCOTT TREPANIER
Director of Special Education/
Early Childhood Coordinator
BRIAN APPERSON
Principal

ATTESTATION/OPT-IN FORM

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; the individual has not had any other contact with a known COVID-19 case outside of school; the person is unvaccinated, or, only partially vaccinated; and the person is 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 administration at the front office window upon entry to 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 OR CHECK-OFF EACH STATEMENT and SIGN BELOW:

___ I have read the *Screen and Stay* guidance document and 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 *Screen 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/work** for a full **14 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 14-day monitoring period.**

- 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:*_____