APPENDIX 1: AFFIRMATION OF INTENT TO COMPLY WITH SCREEN 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 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** 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*