Lakewood School District | 17110 16th Drive NE | Marysville, WA 98271 | 360-652-4500 (office) | 360-652-4502 (fax)

Test to Stay Agreement

Please read carefully the following informed consent.

I hereby consent to abide by all of the following conditions specified by the Washington State Department of Health, Snohomish County Health District and Lakewood School District.

I understand that by signing this agreement, I will allow this student to participate in the Test to Stay Program should they be identified as a close contact to someone who has tested positive for COVID-19. I understand that I can revoke this agreement at any time. I understand that I will be notified of the close contact and can inform the school of my intention to participate in this program at that time.

I understand this agreement will allow this student to do the following during a modified quarantine:

- Attend academic classes in person
- Attend extracurricular activities
- Attend co-curricular activities after school (ex. Band practice, theater practice, club meetings, etc)

I understand that this agreement **will not** allow this student to:

- Attend community events
- Attend before or after school daycare

To meet the conditions of this modified quarantine, the student will:

- Be tested for COVID-19 two times during the modified quarantine
  - The rapid antigen test must be performed on campus by a trained school employee. There will be no cost to the student for this test.
  - Results of these tests are reported to the CDC via simplereport.gov as required by the terms of the MOA with the Snohomish County Health District
- Test negative for COVID-19 throughout the quarantine period
- Monitor closely for symptoms associated with COVID-19 and report any symptoms to the building nurse as soon as possible
- Wear a mask at all times while on campus, unless eating or drinking

Please carefully read the following notice and sign the authorization to test for COVID-19.

1. I understand that the COVID-19 testing will be conducted through a rapid antigen test provided by the Washington State Department of Health.
2. I understand that my ability to receive testing is limited to the availability of test supplies.
3. I understand the entity performing the test is not acting as my medical provider. Testing does not replace treatment by a medical provider. I assume complete and full responsibility to take appropriate action with regard to my test results and my medical care. I agree I will seek medical advice, care and

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treatment from a medical provider or other health entity if I have questions or concerns, if I develop symptoms of COVID-19, or if my condition worsens.

4. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.
5. I understand that it is my responsibility to inform my health care provider of a positive test result, and that a copy will not be sent to my health care provider for me.
6. I understand that my antigen test result will be available in 15-30 minutes.
7. I understand and acknowledge that a positive antigen test is an indication that I need to self-isolate to avoid infecting others.
8. I have been informed of the test purpose, procedures, and potential risks and benefits. I will have the opportunity to ask questions before proceeding with a COVID-19 test. I understand that if I do not wish to continue with the COVID-19 diagnostic test, I may decline to test.
9. I understand that to ensure public health and safety and to control the spread of COVID-19, my test results may be shared without my individual authorization.
10. I understand that my test results will be disclosed to the appropriate public health authorities as required by law.
11. I understand that I may withdraw my consent to participate in testing at any time.

Be electronically signing this document, I hereby authorize the individual to undergo COVID-19 testing using a rapid antigen test.

I also hereby agree to follow all of conditions of the Test to Stay Program. If any of the above conditions are not met, I understand that the individual will need to quarantine out of school after exposure per the most recent Snohomish County Health District quarantine guidelines.

Student Name	
Date of Birth	
Parent Signature	
Today's Date	