



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 that the Test to Stay Program is only available for student whose exposure to someone with COVID-19 occurs while at school. This program will not be used for students who are exposed in other manners, such as household exposures or community based exposures.

I understand this agreement will allow this student to do the following during a modified quarantine the 7 days following exposure:

- Attend academic classes in person

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

- Attend extracurricular activities
- Attend co-curricular activities after school (ex. Band practice, theater practice, club meetings, etc)
- Attend community events
- Attend before or after school daycare

To meet the conditions of this 7-day modified quarantine, the student will:

- Be tested for COVID-19 two times during the 7-day modified quarantine
 - The BinaxNOW 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](https://www.cdc.gov/simplereport) 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

On day 8 after exposure, the individual may return to all normal activities while continuing to monitor closely for symptoms.



LAKWOOD SCHOOL DISTRICT

"In Partnership for Quality Education"

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

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 an Abbott Laboratories BinaxNOW 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 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. If the result is positive, it will need to be confirmed with a PCR test, which I am responsible for obtaining.
7. I understand and acknowledge that a positive antigen test is an indication that I need to self-isolate to avoid infecting others until I obtain a negative PCR test result.
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 the BinaxNOW rapid AG 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 for 14 days after exposure.

Student Name	
Date of Birth	
Parent Signature	



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Today's Date	
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