

STAFF AFFIRMATION OF OVER THE COUNTER (OTC)
COVID-19 ANTIGEN TEST RESULT TO RETURN TO SCHOOL

This form should be completed by the employee prior to return to school following COVID-19 symptoms.

Staff Member's Name (please print):
Date of Birth:
Vaccination Status (circle one): Fully Vaccinated Not Fully Vaccinated

I do hereby affirm that I have tested **NEGATIVE** on two over-the-counter (at home) COVID-19 antigen tests at least 36 hours (1.5 days) apart and that I have experienced a resolution of symptoms permissible to return to school.

OTC Test #1	Date:	Time: am/pm
OTC Test #1 Result (circle one): Negative		Positive

OTC Test #2	Date:	Time: am/pm
OTC Test #2 Result (circle one): Negative		Positive

Signature: _____ Date: _____

BY SIGNING YOU ARE PLEDGING TO THE ACCURACY OF THE INFORMATION YOU HAVE PROVIDED ON THIS FORM.

FOR SCHOOL/OFFICE USE ONLY
Date Received:
Reviewed By:
Comments/Notes: