SACRED HEART SCHOOL
11 5TH ST SW
PO BOX 249
ADAMS, MN 55909

SHORTENED QUARANTINE REQUEST (FOR CLOSE CONTACTS)

Per the updated MDH close contact guidelines, students who have one close contact experience may be considered for an earlier return date to school if they meet certain criteria. To request an early return for your child please fill out the following areas and provide any necessary supporting documentation. For ALL early returns, students must have no symptoms and have had only one close contact exposure.

***If a household member is positive for COVID, you do not qualify for early return and need to quarantine for the full 14 days.**

Student Name (print clearly): _____

Parent/Guardian Name(s): _____

Age, Grade, School: _____

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10 DAY QUARANTINE REQUEST (return after finishing 10 full days of quarantine)

Check the following that apply to your child (ALL must be checked to qualify):

- ❑ 1) My child has no symptoms
- ❑ 2) My child has NOT tested positive for COVID
- ❑ 3) No one in my child's household has tested positive for COVID
- ❑ 4) After the 10-day quarantine, I agree to monitor my child for symptoms through day 14 and keep them home if ***any*** symptoms would appear

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7 DAY QUARANTINE REQUEST (return after finishing 7 full days of quarantine)

Check the following that apply to your child (ALL must be checked to qualify):

- ❑ 1) My child has been tested for COVID-19 ***at least five full days*** after their close contact exposure, and the test is negative. To qualify, **test must be a PCR test** - please check with your doctor. Negative results with appropriate date (5+ days after exposure) must be provided to the school with this form.
  **Please note, day one starts the day after exposure. Ex: close contact occurred on Friday at 3pm , earliest date of test could be Wednesday at 3 pm (Sat = day 1, Sun = day 2, Mon = day 3, Tue = day 4, Wed = day 5)*
- ❑ 2) My child has no symptoms
- ❑ 3) After the 7 day quarantine, I agree to monitor my child for symptoms through day 14 and keep them home if ***any*** symptoms would appear

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Documentation of a PCR COVID-19 negative test must be attached to this form if a 7-day quarantine is being requested. By signing this, you agree that the above checkmarks are all correct.

Parent Signature _____ Date _____

District Rep. Signature _____ Date _____