

7 Day Shortened Quarantine Request – For Close Contacts ONLY

PER the [new 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. The Prep Health Office reserves the right to deny any request based on current in building situations. 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. MDH does recommend 14 days as the safest quarantine option.

***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): _____

Grade/Teacher or Division: _____

7 DAY QUARANTINE REQUEST (return after finishing 7 full days of quarantine, return date is day 8)

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

- ☐ 1) My child has been tested for COVID-19 **day 5 or later** after their close contact exposure, and the test is negative. To qualify, **test must be a Molecular test** – not an antigen 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, earliest date of test could be Monday (Sat = day 1, Sun = day 2, Mon = day 3, Tue = day 4, Wed = day 5)*
- ☐ 1) My child has no less common symptoms AND no more common symptoms associated with COVID (please refer to [MDH Decision Tree](#) for Schools for list of symptoms)
- ☐ 2) My child has NOT tested positive for COVID-19
- ☐ 3) No one in my child's household has tested positive for COVID-19
- ☐ 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 and notify the Health Office

Please attach to this form any supporting documentation of a Molecular Covid negative test (if 7 day quarantine is being requested). By signing this, you agree that the above checkmarks are all correct.

Parent Signature _____ Date _____

FORM MUST BE TURNED IN TO THE HEALTH OFFICE FOR APPROVAL PRIOR TO ATTENDING CLASS

For Health Office Use only: ____ Approved ____ Declined/Reason _____