Wallingford Swarthmore School District

Parent/Guardian Permission for Optional Test-to-Stay Program

Please read and initial the box on the right.

I understand that participation in the Test to Stay program is optional.	**Initials**
I understand that participation in the Test to Stay program will continue while my child remains in schools without any signs or symptoms of COVID-19. I agree to contact my child's school immediately if my child begins showing symptoms.	**Initials**
I understand my child may be tested and will need to wait 20 minutes in their respective school parking lot before entering the building to ensure the test is negative. I understand I cannot wait in the drive by testing line to wait for results.	**Initials**
I understand and agree that my child will complete the required three tests of the Test to Stay program. Failure to do so may require a PCR test to return to school.	**Initials**
I understand if my child tests positive, my child is required to isolate for 10-days.	**Initials**

Student Name: _____

School Building: _____

Parent/Guardian:
(Print Name) _____

Parent/Guardian:
(Signature) _____

Contact Number: _____

Date: _____