



Northern Adirondack Central School District

Office of the Superintendent
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NACS Staff Home/Antigen Test *Return to Work* Attestation

Name of Individual: _____

Employee Other: _____

Test #1 Date/Time: _____

Test Result (please check one): Positive Negative

Test #2 Date/Time: _____ (must take place between 24-48 hours after test #1) Test

Result (please check one): Positive Negative

NOTE: DO NOT COME TO WORK IF EITHER TEST IS POSITIVE.

Please attest to the following:

- I attest that the person whose name appears at the top of this form is the individual for whom the given test results applies.
- I attest that the test was administered correctly according to the package insert.
- I attest that the second test was administered between 24-48 after the first test.
- I attest that I have been fever-free for 24 hours without the use of fever-reducing medication

Signature of individual: _____

Printed name of individual: _____

Please contact the District Office if you have any questions regarding these guidelines