

TO BE COMPLETED BY PARENT, GUARDIAN OR ADULT STUDENT

Parent/Guardian Information

You will be notified with test results either via cell phone or email, or both.

| | |
|---|--|
| Parent/Guardian Print Name: | |
| Parent/Guardian Cell/Mobile#: <i>Note: results will be texted to this cell#</i> | |
| Parent/Guardian Email Address: | |

Child/Student Information

| | | | | |
|--|--|---|---|---|
| Child/Student Print Name: | | | | |
| School ID #: | | | | |
| Healthcare Provider/ Phone Number: | | | | |
| Street Address: | | City: | | State: |
| Zip Code: | | County: | | |
| School: | | Grade Level: | | |
| Date of Birth: <i>(MM/DD/YYYY)</i> | | Age: | | |
| Race/Ethnicity: | <input type="checkbox"/> Asian <input type="checkbox"/> Black | <input type="checkbox"/> Hispanic <input type="checkbox"/> White | <input type="checkbox"/> Native American/Indigenous <input type="checkbox"/> Unknown | Gender: |
| | | | | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other/Unknown |

CONSENT

By signing below, I attest that:

- A. I consent, and authorize the school system to conduct collection and testing of my child or me (if student age 18 or older) for COVID-19 by nasal swab.
- B. I acknowledge that a positive test result is an indication that my child or me (if student age 18 or older), must self-isolate in an effort to avoid infecting others.
- C. I understand the school system is not acting as my child's medical provider, this testing does not replace treatment by my child's medical provider, and I assume complete and full responsibility to take appropriate action with regards to my child's test results. I agree I will seek medical advice, care and treatment from my child's medical provider if I have questions or concerns, or if their condition worsens.
- D. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.
- E. I understand that this test may occur multiple times throughout the 2021-2022 school year, and authorize testing of my child or myself (if student age 18 or older) throughout the 2021-2022 school year. I understand that this authorization may be rescinded by providing signed written notice of rescission to the school system.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily consent, and agree to this testing for COVID-19.

| | | | |
|---|--|--------------|--|
| Signature of Parent/Guardian: | | Date: | |
| Signature of Student: <i>(if age 18 or over or otherwise authorized to consent)</i> | | Date: | |