

**COVID-19 Testing: Informed Consent**

Please carefully read and sign the following Informed Consent:

- a. I authorize USD \_\_\_\_\_ to conduct collection and testing for COVID-19 of my child through an anterior nasal swab specimen to be obtained in accordance with the manufacturer’s instruction.
  - i. For diagnostic testing (i.e. child has symptoms): \_\_\_\_\_ Yes \_\_\_\_\_ No
  - ii. For Test to Stay testing (i.e. child is a close contact): \_\_\_\_\_ Yes \_\_\_\_\_ No
- b. I authorize the school to notify me of my child’s test results via my communication preference designated at enrollment unless otherwise specified in writing.
- c. I authorize my child’s test results to be disclosed to the county, state, or to any other health entity as may be required by law.
- d. I acknowledge that a positive test result is an indication that my child must isolate in accordance with KDHE and County guidelines to avoid infecting others. I also agree to assist the school with identification of any close contacts which occurred within the 48 hours prior to test sample collection.
- e. I understand that the school is not acting as my child’s medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.
- f. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.
- g. I understand that this consent form will be valid through June 30, 2023, unless I notify the school in writing that I revoke my consent.

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 agree to this testing for COVID-19.

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Parent or Guardian Name (Print)

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date