COVID-19 ANTIGEN TESTING CONSENT FORM

THIS FORM MUST BE SIGNED PRIOR TO TESTING

PLEASE COMPLETE THE INFORMATION BELOW

Full, Legal name of Student (*First, Middle Initial, Last Name)* Please Print	Name of School
ETHNICITY (CIRCLE ONE) Hispanic Non-Hispanic Other	RACE Sex
Street Address Email Address	Birth Date (MM/DD/YYYY) Age
City Zip Code	Home Phone # Cell Phone #

This consent form acknowledges my permission to participate in Antigen testing for the purpose of screening.

Why is the student being screened?

"Screening" is the testing of people for COVID-19 who are asymptomatic and have no known exposure to someone who currently has COVID-19. If someone has COVID-19, but doesn't know it because they have no symptoms, screening will help identify positive cases so it is spread to fewer people. Test results can be read in 15 minutes, which makes Antigen testing (or screening) efficient for instances like sports teams that need to travel and must be tested within a certain time frame in order to participate.

How is the test conducted?

Samples for testing will be collected by using a nose swab (small swab put into the front part of the nose). The swab will then be placed in a folding card and the test administrator will apply reagent and set a timer. The test results will be read after 15 minutes.

What to Do After Testing

If the result is positive, you will need to leave the building and contact your doctor for confirmatory PCR testing.

By signing this form for myself or on behalf of my student, I agree and attest to the following:

- I have signed this form freely and voluntarily.
- I consent to COVID-19 Antigen testing for the purpose of screening.
- I authorize COVID-19 testing to be conducted via collection and testing through a nasal swab, as recommended by a medical provider, school nurse, or public health official. I understand that testing may

happen several times a week and that I can refuse at any time. This consent extends to COVID-19 testing performed during the 2021-2022 academic year.

- I understand and authorize the test results and other information to be disclosed as permitted by law.
- I acknowledge that a positive test result is an indication of a requirement to self-isolate and wear a mask or face covering as directed.
- I understand that the Southeast Island School District is not acting as a medical provider and that this testing does not replace treatment by a licensed medical professional.
- I assume complete and full responsibility to take appropriate action when I receive the test results either for myself or for my student. I agree I will seek medical advice, care and treatment for myself and my student.
- I understand that, as with any medical test, there is the potential for a false positive or a false negative COVID-19 test result.
- I understand that there will be no out-of-pocket cost for this testing.
- I understand that this consent form will be valid through June 30, 2022, unless I notify the District, in writing, that I revoke my consent.
- I freely give this consent and I do hereby release and hold harmless the Southeast Island School District from any and all liability or damage which may result from the disclosure of information herein authorized.

Printed Name of Parent or Guardian (or student if 18 or over)	[redacted]
Signature of Parent (or student if 18 or over)	Date