

# STUDENT CONSENT FORM FOR OPTIONAL COVID-19 TESTING

## TO BE COMPLETED BY PARENT / GUARDIAN

### Parent/Guardian Information

- If your student has tested positive for COVID-19 in the past 90 days, they should not participate in COVID-19 testing to avoid false positives.

Parent/Guardian  
Print Name:

Parent/Guardian Cell/Mobile #:  
*Note: results will be texted to this cell #*

Parent/Guardian  
Email Address:

### Child/Student Information

Child/Student Print Name:

Grade Level:

Date of Birth:  
(MM/DD/YYYY)

Address:

City:

Zip Code:

Race (pick one):

- ☐ American Indian/Alaskan Native
 ☐ Asian
 ☐ Black/African American  
☐ Native Hawaiian/Pacific Islander
 ☐ White
 ☐ Other
 ☐ Prefer not to say

Ethnicity (pick one):

- ☐ Hispanic or Latinx  
☐ Not Hispanic or Latinx  
☐ Prefer not to say

Gender:

(if more one option applies, please select *Other*)

- ☐ Male
 ☐ Transgender  
☐ Female
 ☐ Nonbinary  
☐ Other
 ☐ Unknown  
☐ Prefer not to say

Consent Opt Out:

- ☐ **Yes**, I provide consent for my student to participate in COVID-19 testing (*please read and sign form below*)  
☐ **No**, I do not provide consent for my student to participate in COVID-19 testing. (*No further action needed*)

### CONSENT

By completing and submitting this form, I confirm that I am the appropriate parent, guardian, or legally authorized individual to provide consent and:

- A. I authorize collection and testing of a sample from my student for COVID-19 at school, whether for an individual test (e.g. individual antigen or PCR test). By signing this form, I am consenting to any of the following testing methods for my student. I understand that my student's school will determine which testing methods are offered to my student and will inform me of the services the school is administering prior to the start of, or any change to, the school's COVID-19 testing program.
  - i. Individual testing on **symptomatic** individuals: for when individuals present symptoms while at school
  - ii. Individual testing on **close contacts (Test and Stay)**: for asymptomatic close contacts to be tested daily for at least five (5) days from the first day of exposure, with individuals testing negative being allowed to remain at school
- B. I understand that all sample types will be non-invasive, short nasal swabs or saliva samples.
- C. I understand and agree that my personal health information and personally identifiable information from education records may be entered into the testing provider's technology platform to assist with tracking safety check testing and identifying individuals in need of individual follow-up testing.

- D. I understand that I will be notified about the results of any individual test for COVID-19 performed on my student.
- E. I understand that there is the potential for a false positive or false negative COVID-19 test result, no matter the kind of testing being performed. Given the potential for a false negative, I understand that my student should continue to follow all COVID-19 safety guidance, and follow school protocols for isolating and testing in the event the student develops symptoms of COVID-19.
- F. I understand that staff administering all COVID-19 testing have received training on safe and proper test administration. I agree that neither the test administrator nor the Fall River Public Schools, nor any of its trustees, officers, employees, or organization sponsors are liable for any accident or injuries that may occur from participation in the COVID-19 testing program.
- G. I understand that my student **must** stay home if feeling unwell. I acknowledge that a positive **individual** test result is an indication that my student must stay home from school, self-isolate, and continue wearing a mask or face covering as directed in an effort to avoid infecting others.
- H. I understand the school system is not acting as my student's medical provider, this testing does not replace treatment by my student's medical provider, and I assume complete and full responsibility to take appropriate action with regards to my student's test results. I agree I will seek medical advice, care and treatment from my student's medical provider if I have questions or concerns, or if their condition worsens. I understand I am financially responsible for any care my student receives from their healthcare provider.
- I. I understand that COVID-19 testing may create protected health information (PHI) and other personally identifiable information of the student, and such information will only be accessed, used, and disclosed in accordance with HIPAA and applicable law. Pursuant to 45 CFR 164.524(c)(3), I authorize and direct the testing provider to transmit such PHI to my student's school, the Massachusetts Department of Public Health, the Massachusetts Executive Office of Health and Human Services, and the testing laboratory. I further understand that PHI may be disclosed to the Executive Office of Health and Human Services and any other party, as authorized under HIPAA.
- J. I understand that participation in COVID-19 testing may require the school to disclose my student's identity, demographic, and contact information from education records to the testing provider and may require the school to disclose my student's identity, demographic, and contact information from education records to the Massachusetts Department of Public Health. Pursuant to FERPA, 34 CFR 99.30, I authorize my school to disclose such personally identifiable information (PII) as is required for my student to participate in COVID-19 testing.
- K. I understand that authorizing these COVID-19 tests for my student is optional and that I can refuse to give this authorization, in which case, my student will not be tested.
- L. I understand that I can change my mind and cancel this permission at any time, but that such cancellation is forward-looking only, and will not affect information previously released. To cancel this permission for COVID-19 testing, I need to contact your child's school nurse.
- M. I authorize the testing provider and/or the Massachusetts Department of Public Health to monitor aspects of the COVID-19 virus, such as tracking viral mutations, by analyzing positive sample(s) for epidemiological and public health purposes. Results of such analyses will not be personally identifiable nor create personally identifiable information.

I, the undersigned, have been informed about the COVID-19 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 for my student.

Signature of Parent/Guardian:

Date: