STAFF/ADULT CONSENT FORM FOR OPTIONAL COVID-19 TESTING

TO BE COMPLETED BY INDIVIDUAL CONSENTING FOR THEMSELVES

INDIVIDUAL Information

- *If you have tested positive for COVID-19 in the past 90 days, you should not participate in COVID-19 testing to avoid false positives.*

Print Name:					
Cell/Mobile #: *Note: results will be texted to this cell #*					
Email Address:					
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 to participate in COVID-19 testing *(please read and sign form below)* **No**, I do not provide consent to participate in COVID-19 testing. *(No further action needed)*				

CONSENT

By completing and submitting this form, I confirm that I am the appropriate individual to provide consent and:

A. I authorize collection and testing of a sample from 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 me. I understand that my school will determine which testing methods are offered to me 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 me.
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 I should continue to follow all COVID-19 safety guidance, and follow school protocols for isolating and testing in the event I develop 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 I **must** stay home if feeling unwell. I acknowledge that a positive **individual** test result is an indication that I 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 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. I understand I am financially responsible for any care I receive from my healthcare provider.
I. I understand that COVID-19 testing may create protected health information (PHI) and other personally identifiable information, 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 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 identity, demographic, and contact information from education records to the testing provider and may require the school to disclose my 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 me to participate in COVID-19 testing.
K. I understand that authorizing these COVID-19 tests for me is optional and that I can refuse to give this authorization, in which case, I will not be tested.

Signature of Individual Consenting:		**Date:**