USD 350 St. John/Hudson Schools
COVID-19 CONSENT TO TESTING

USD 350 is participating in a PILOT KDHE SCHOOL COVID-19 Testing Program.

Your child has the opportunity to be tested at school with a rapid COVID-19 test. If your child tests positive, it is required he/she has another COVID-19 test within 48 hours. That test can also be given at school and will be sent to the state lab for testing or you are free to see your medical provider**.**

Name:_____

Date of Birth_____ **Street Address**_____

Home Phone_____ **Cell Phone**_____

Email Address_____

Authorization and Consent to Test for COVID-19 testing: I voluntarily consent and authorize USD 350 Health Services to conduct collection, testing, and analysis for the purposes of a COVID-19 diagnostic test. I acknowledge and understand that my child's COVID-19 diagnostic test will require the collection of an appropriate sample by the school nurse through a nasal swab for rapid testing and if child is positive a nasopharyngeal swab for a PCR test according to the manufacturer's stated directions. I understand that there are risks and benefits associated with undergoing a diagnostic test for COVID-19 and there may be a potential for false positive or false negative test results. I understand the testing unit 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 my child's condition worsens.

Release of Testing Results: I acknowledge that my child's COVID-19 test results and associated information will be released or obtained by KDHE for the pilot study and if positive will be released to Stafford County Health Department or the Health Department in the county you live to control, prevent, or mitigate the spread of COVID-19 as is required by law.

Release: To the fullest extent permitted by law, I hereby release, discharge and hold harmless the **USD 350 St. John/Hudson Schools**, including, without limitation, any its respective officers, directors, employees, representatives and agents from any and all claims, liability, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to my child's COVID-19 diagnostic test or the disclosure of my child's COVID-19 test results.

I acknowledge and agree that I have read, understand, and agreed to the statements contained within this form. I have been informed about the purpose of the COVID-19 diagnostic test, procedures to be performed, potential risks and benefits, and associated costs. I have been provided an opportunity to ask questions before proceeding with a COVID-19 diagnostic test and I understand that if I do not wish to continue with the collection, testing, or analysis of a COVID-19 diagnostic test for my child, I may decline to receive continued services. I have read the contents of this form in its entirety and voluntarily consent to undergo diagnostic testing for COVID-19.

Parent/Legal Guardian Signature:

_____Date: _____

CHILD'S PRIMARY CARE PROVIDER:_____