COVID-19 Testing Permission Form

TO BE COMPLETED BY PARENT/GUARDIAN:

Student Name:	
Student Birthdate:	Age:
School:	Grade:
Parent/Guardian Name(s):	
Home Address:	
Phone Number:	
Email Address:	

Highline Public Schools has collaborated with the Washington State Department of Health to be able to offer free COVID-19 testing to students, staff, and families. The COVID-19 tests are shallow nasal swabs, which are quick and painless, and will be self-administered under observation by a trained person. We require your informed consent for the above-mentioned student (hereafter referred to as "my student") to be able to participate in diagnostic, screening, and follow-up (reflex) COVID testing.

SCREENING TESTING PERMISSIONS (Atlas Genomics)

- I authorize my student to participate in the pooled COVID-19 testing program to include weekly collection of specimens during school hours by school personnel and subsequent analysis by Atlas Genomics.
- I understand that I will not receive an individual result for my student from the pooled testing and that such individual results from pooled testing cannot be provided to me. My student's personal health information and personally identifiable information from education records will not be provided to Atlas Genomics in connection with it performing COVID-19 pooled testing.
- I understand that in the event of a positive test result within my student's screening testing cohort, follow-up or reflex testing will be necessary to determine the positive case(s) within the cohort.

DIAGNOSTIC TESTING PERMISSIONS (Curative, Atlas Genomics, and BinaxNOW Rapid Antigen Tests by Highline Staff)

- I understand that in the event of a positive test result within my student's screening testing cohort, follow-up or reflex testing will be necessary to determine the positive case(s) within the cohort via the Abbott Labs BinaxNOW Rapid Antigen test, Curative PCR testing, or Atlas Genomics PCR testing. Testing will be self-administered and observed by trained school personnel.
- I understand and acknowledge that a positive diagnostic test result is an indication that the above-named student needs to self-isolate to avoid infecting others.
- By indicating my consent below, I authorize Atlas Genomics and/or Curative to release the results of my student's COVID-19 test results to Highline Public Schools. This information will be used to make sure our students and staff can be safely at school during the COVID-19 pandemic.
- I authorize Atlas Genomics, LLC, Curative Inc., and Curative Labs, LLC, as applicable, to disclose my student's protected health information to Highline Public Schools
- I affirm that Highline Public Schools has the legal authority to determine who may receive the protected health and education information pertaining to the student.
- I have the right to revoke this authorization at any time by doing so in writing to support@curativeinc.com.
- Any revocation of this authorization by me will not apply to actions that any of Atlas Genomics, LLC, Curative Inc., Curative Labs, LLC, and/or Dr. Sajad Zalzala M.D. have already taken regarding the sharing of protected health information during the period that my authorization was valid.

COVID-19 TESTING PERMISSIONS - ALL

- I understand that false positive or false negative COVID-19 test results may occur in pooled or individual tests. Due to the potential for a false negative result, I understand that my student should continue to follow all COVID-19 safety guidance, including mask-wearing and social distancing, and follow school protocols for isolating and testing in the event my student develops symptoms of COVID-19.
- I understand that the personnel administering pooled and follow-up testing have received appropriate training on how to properly administer the test using all applicable safety guidelines. I agree that neither the test administrator nor Highline Public Schools, nor any of its trustees, officers, employees, or organization sponsors are liable for any accident or injuries that may occur from my student's participation in the testing program.
- I understand that the antigen test result will be available in 15-30 minutes.
- I understand that my student **must** stay home if feeling unwell. I acknowledge that a positive individual follow-up test result requires that my student stay home from school, self-isolate, and continue wearing a mask or face covering as directed by school or public health officials.
- I understand the school system is not acting as my student's medical provider or providing any medical advice and that this testing does not replace treatment by my student's medical provider. I assume complete and full responsibility to takeappropriate action with regards to my student's test results and 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 understand it is my responsibility to inform the above-named student's health care provider of a positive test result, and that a copy will not be sent to the above-named student's health care provider for me.
- I understand that the test results will be disclosed to the appropriate public health authorities, the Office of Superintendent of Public Instruction, and as otherwise permitted or required by law.
- I understand that authorizing COVID-19 testing for my student is optional and that I may refuse to give this authorization, in which case, my student will not be tested.
- I understand that I may cancel this authorization at any time, but that such cancellation applies to future testing only, and will not affect information I already authorized to be released. To cancel this authorization for COVID-19 testing, I must contact my student's school.

☐ **I consent to weekly screening testing for my student for the 2021-2022 school year.** *OPTIONAL BUT ENCOURAGED.* By checking this box and signing below, I, the undersigned, have been informed about the test purpose, procedures, potential risks, and I have received a copy of this Informed Consent. I have been provided the opportunity to ask questions before I sign, and I have been told that I may ask additional questions at any time. I voluntarily agree to authorize COVID-19 screening testing for my student. In the event that my student's pool testing cohort tests positive for COVID-19, I authorize my student to participate in additional follow-up diagnostic testing as necessary.

☐ **I consent to diagnostic testing for my student for the 2021-2022 school year.** *OPTIONAL BUT ENCOURAGED.* By checking this box and signing below, I voluntarily agree to authorize my student to be tested if they have symptoms or had exposure to a positive individual via Atlas Genomics PCR, Curative PCR, and/or Abbott Labs BinaxNOW Rapid Antigen COVID-19 tests. I further authorize the School District to share my student's birthdate to Atlas Genomics, Curative and Abbott, as applicable, for identification purposes. Finally, I understand that, per the Washington State Department of Health, a student with COVID-19 or COVID-19 symptoms cannot attend school in person.

_____	_____	_____
Signature of Parent/Legal Guardian OR Student (age 18 or older)	**Printed Name of Parent/Legal Guardian OR Student (age 18 or older)**	**Date**

Received by School District on: _____
Date

Full consent forms, COVID authorization forms, and additional information regarding specific tests is available for you to review at: https://drive.google.com/drive/folders/1o02Y2va6Nl3cwldBFPoDIOPlUGvk3wOg?usp=sharing

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