

CONSENT FORM FOR OPTIONAL COVID-19 TESTING

Del Valle ISD takes the health and safety of our students, staff, and their families very seriously. As such, in addition to steps to screen for the virus and prevent its spread on a campus, we are adding a voluntary K-12 COVID-19 testing program for students. This program uses GenBody tests provided by the federal government. We will only test with your consent. If you are willing to provide consent for us to administer this test on your child or yourself (if age 18 or older), please fill out this form.

What is the test?

If the client/ student is symptomatic or part of a group that is designated for testing, and consent, the client/ student will receive a free GenBody rapid test for the COVID-19 virus. Collecting a specimen for testing involves using a swab, similar to a Q-Tip, placed inside the tip of the nose. A school staff member who has been trained to use this test will collect the specimen and a trained COVID-19 test administrator will oversee the process. Test results will be made available to the client or parent/guardian who signs this form below. The results will be given at time of testing. This program is **entirely optional** for students and staff.

What should I do when I receive the test results?

Follow the guidance on the official letter of Covid Rapid Test Results.

Known Symptoms:

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear **2-14 days after exposure to the virus**. People with these symptoms may have COVID-19:

- Feeling feverish or a measured temperature greater than or equal to 100.0 degrees Fahrenheit
- Loss of taste or smell
- Cough
- Difficulty breathing
- Shortness of breath
- Fatigue
- Headache
- Chills
- Sore throat
- Congestion or runny nose
- Shaking or exaggerated shivering
- Significant muscle pain or ache
- Diarrhea
- Nausea or vomiting

This list does not include all possible symptoms.

Disclaimer:

While we realize precautions will be taken for the safety of students, please understand that neither the test administrator nor the Del Valle ISD, nor any of its trustees, officers, employees, or organization sponsors are liable for any accident or injuries that may occur to your child or yourself (if age 18 or older), as a result of agreeing to the test.

TO BE COMPLETED BY PARENT, GUARDIAN OR CLIENT

Client/ Student Information

Client/ Student Print Name:					
Parent/Guardian Print Name (if client under age 18):					
Cell/Mobile #:					
Email Address:					
Street Address:		City:		State:	
Zip Code:		County:			
School:				Grade (if applies):	
Date of Birth: (MM/DD/YYYY)				Age:	
Race/Ethnicity: (circle)	Asian	Hispanic	Native American/Indigenous	Gender: (circle)	Male Female Other/Unknown
	Black	White	Unknown		

CONSENT

By signing below, I attest that:

- A. I authorize the school system to conduct collection and testing of my child or me for COVID-19 by nasal swab.
- B. I acknowledge that a positive test result is an indication that my child or me, must self-isolate and also continue wearing a mask or face covering as directed in an effort to avoid infecting others.
- C. I understand the school system is not acting as myself or my child's medical provider, this testing does not replace treatment by myself or my child's medical provider, and I assume complete and full responsibility to take appropriate action with regards to me or my child's test results. I agree I will seek medical advice, care and treatment from my or my child's medical provider if I have questions or concerns, or if their condition worsens.
- D. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

I, the undersigned, have been informed about the 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.

Signature of Parent/ Guardian:		Date:	
Signature of Client/ Student: (if age 18 or over)		Date:	

FOR TESTING STAFF ONLY:
 DATE SYMPTOMS STARTED:
 CLOSE CONTACT:
 LAST DAY ON CAMPUS:
 RESULT: