



Please carefully read and sign the following Informed COVID 19 Screening Test Consent and Authorization for the Release of Information and Test Results:

For non-minors, all sections that reference "my child" refer to the individual signing

To help make our California schools safer and reduce the risk of COVID-19 being transmitted at school, the California Department of Public Health (CDPH) in partnership with your school is implementing a COVID-19 testing program. The COVID-19 tests under this program may include, but not be limited to, self-administered over-the-counter antigen tests, school administered antigen tests, and molecular (e.g., PCR) and pooled molecular tests. Students and staff who are studying or working at the school maybe tested one to two times a week for COVID-19. All testing will be free of charge.

This consent is valid through August 1, 2021 through June 30,2022.

Rapid tests results will generally be available within one hour. If additional confirmatory laboratory-based testing is needed, you will be notified. You will receive a message when the test result is available for both negative and positive cases.

This document provides consent for participation in the school-based testing program:

- I authorize on behalf of myself or my child COVID-19 testing by collecting a nasal swab. Most children and adults will swab the first inch or so of their nose themselves.
- I represent that I am the parent or guardian authorized to sign this document for my child.
- I acknowledge that a positive test result is an indication that I or my child must isolate at home, follow state and county quarantining procedures, and wear a mask or face covering as directed in an effort to avoid infecting others.
- I authorize that my or my child's test results may be disclosed to the district, county or state health department, or to any other governmental entity.
- For students between the ages of 13-17 years: I acknowledge that a positive test results will be shared with my parent or guardian on file with the school.
- I authorize Primary Diagnostics, Inc. ("Primary") and each of the parties listed below to release patient personal and test information in order facilitate testing for COVID-19 infection and for making further disclosures as set forth in the Primary Privacy Policy, available at <https://primary.health>:
 - The ordering provider for your COVID-19 test
 - The ordering provider for your child's COVID-19 test
 - The California Department of Public Health and local public health agencies
 - Any laboratory partner providing confirmation RT-PCR tests and/or providing mandatory reporting to the state health department
 - The participating school and other Primary partners, as necessary and determined by Primary Diagnostics, Inc.

- I understand that “patient personal and test information” includes the following:
 - The patient’s name, gender, date of birth
 - If applicable, dependent and/or guardianship information
 - Contact information including telephone number, email address, and physical or mailing address
 - Appointment information, transaction identification number, COVID-19 test information and results

- I understand that this testing site does not act as a medical provider and that testing does not replace treatment by a medical provider. I assume complete and full responsibility to take appropriate action with regards to the test results. I agree I will seek medical advice, care, and treatment from a medical provider, as applicable, if I have questions or concerns, or if conditions worsen.

- I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result. I have been informed about the test purpose, procedures, possible benefits and risks, and, if requested, have received a copy of this Informed Consent for participation in the COVID-19 test. I have been given the opportunity to ask questions before I sign, and throughout the entire testing procedure.

- I understand that I may revoke my authorization for consent at any time by notifying Primary.Health in writing at Primary Diagnostics, Inc. at 595 Pacific Ave FL4, San Francisco, CA 94133 or support@primary.health of my desire to revoke it. In addition to notifying Primary Diagnostics, I must also provide written notice to the designated school. I understand that any action already taken in reliance on this authorization prior to my revocation cannot be reversed.

- I understand the school may also request and conduct molecular (e.g., PCR) tests as an additional precautionary measure for certain individuals tested through the COVID antigen rapid test screener. For example if a person who was exposed or has no symptoms tests positive. In this instance, I authorize the California Department of Public Health and designated partners to use my insurance information to ensure that there is no cost to me for this service

Warning of Risks & Assumption of Risks:

Participating in COVID-19 screening involves inherent health risks. There is a risk that upper respiratory tract swabbing may cause mild discomfort, sneezing, or nosebleed. By consenting to participate, I acknowledge that I understand that the risk of my or my child’s participation is low, and I voluntarily accept any health risks.

Waiver, Release, and Indemnification:

I know that participating in this screening is an activity that may be a potentially hazardous activity for some individuals. I hereby assume full and complete responsibility for any injury, illness, or accident which may occur during my or my child’s participation. I hereby release, waive, hold harmless and covenant not to bring a suit against the administrators, sponsors, organizers, volunteers, employees, agents or any affiliated individuals or entities associated with this screening from any and all losses, damages, liabilities or other claims and causes of action that may arise out of my participation.

- To the extent permitted by applicable law, in the event of a conflict between the English and another language version of this Informed Consent, the English language version shall control.

Note: Electronic Consent will be collected through the Primary.Health platform. If written or

verbal consent is needed, the electronic consent may be exported to a printable format with the appropriate signature lines and information.

Name of participant: _____ Date: _____

Signature of participant: _____

AND/OR

Name of parent/guardian: _____ Date: _____

Signature of parent/guardian: _____