



THE SCHOOL HEALTH PROGRAM OF PALM BEACH COUNTY

CONSENT TO COVID-19 and/or INFLUENZA TESTING AND AUTHORIZATION FOR RELEASE OF RECORDS

The School Health Program, which is comprised of the Palm Beach County School District ("School District"), the HealthCare District of Palm Beach County ("Health Care District") and the Florida Department of Health Palm Beach County ("Department of Health") is offering to conduct voluntary COVID-19 and/or Influenza testing for students who present to a School District clinic with symptoms of COVID-19¹ or Influenza, to protect the health, safety and welfare of students and staff of the School District. This voluntary testing is being conducted, to the extent these tests are available, at no cost to you.

Testing Information: The COVID-19 test that would be administered to your child is either a rapid-antigen test or a rapid molecular test, both of which have been approved by the FDA under emergency use authorizations. The Influenza test has FDA approval. Each of these tests involve the swabbing of your child's nasal passage(s) to obtain a sample for testing. There are risks and benefits with undergoing such a diagnostic test and there may be a potential for false positive or false negative test results. Additionally, the actual test may cause slight discomfort to your child's nose or throat during the collection process and for a short period of time thereafter. You will be provided with the results of your child's test and it will be your responsibility to seek advice and treatment from your medical provider if necessary. You may also contact the school nurse for additional information.

CONSENT TO TEST: By your signature below, you certify that you have read and understood this COVID-19/Influenza Testing Consent. More specifically, by signing below you:

- Give your permission for your child to be tested for:
☐ COVID-19
☐ INFLUENZA *(please check one or both)*
- Understand that the trained designee will determine which test(s) to administer based upon symptoms, with authorization provided;
- Release the School Health Program from all liability which arises from or is a result of the testing;
- Understand that it is your responsibility to seek advice and treatment from your medical provider, if necessary;
- Understand that this authorization is valid until revoked in writing.

STUDENT PRIVACY: The School Health Program complies with all applicable federal and state privacy laws. All COVID-19 and Influenza screening and testing records are confidential education records under the Family Educational Rights and Privacy Act ("FERPA"). Generally, under FERPA, your child's education records may only be disclosed with your consent unless there is an applicable exception. While there are exceptions applicable to COVID-19 screening and testing records requiring the records to be provided to the Department of Health and allowing the records to be provided to the School District, by signing below, you are authorizing the School Health Program to release your child's COVID and/or Influenza test and screening records to the Department of Health and/or the School District.

Please be advised that as the parent or guardian, you will be contacted by a nurse or administrator/designee prior to any testing, even with this consent on file. Verbal authorization to proceed with testing will be accepted, with this consent on file, with the parent or guardian having the option of being present for testing.

Parent/Guardian (Print): _____

Parent/Guardian Signature _____ Date: _____

Mobile Telephone: _____ Other Telephone: _____ (home/work)

Student Signature (If over 18): _____ Date: _____

Student Name (Print): _____

School: _____ Grade: _____

¹ COVID-19 symptoms may include fever or chills, dry cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of sense of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea, per the CDC Guidelines