

**STUDENT CONSENT FORM FOR OPTIONAL COVID-19 TESTING
TO BE COMPLETED BY PARENT / GUARDIAN**

Parent / Guardian Information

Unvaccinated and vaccinated individuals may participate in symptomatic testing

Parent/ Guardian Print Name:	
Parent/ Guardian Cell #:	

Student Information

Student Print Name:			
Date of Birth: (MM/DD/YYYY)		Gender:	
Address:			
Race:		Ethnicity:	
Consent Opt In	Yes, I provide consent for my student to participate in COVID-19 testing (please read and sign form below)		

CONSENT

By completing and submitting this form, I confirm that I am the appropriate parent, guardian, or legally authorized individual to provide consent and:

- A. I authorize collection and testing of a sample from my student for COVID-19 at school for testing on symptomatic individuals and to receive self-tests for at-home collection. By signing this form, I am consenting to the following testing method for my student.
 - i. Individual testing on symptomatic individuals: for when individuals present symptoms while at school
- B. I understand that all sample types will be non-invasive, short nasal swabs
- C. I understand that I will be notified about the results of any individual test for COVID-19 performed on my student.
- D. I understand that there is the potential for a false positive or false negative COVID-19 test result, no matter the kind of testing being performed. Given the potential for a false negative, I understand that my student should continue to follow all COVID-19 safety guidance, and follow school protocols for isolating in the event the student develops symptoms of COVID-19.
- E. I understand that staff administering COVID-19 testing have received training on safe and proper test administration. I agree that neither the test administrator nor the Lynn Public Schools, nor any of its trustees, officers, employees, or organization sponsors are liable for any accident or injuries that may occur from participation in the COVID-19 testing program.
- F. I understand that my student must stay home if feeling unwell. I acknowledge that a positive individual test result is an indication that my student must stay home from school, self-isolate, and continue wearing a mask or face covering as directed in an effort to avoid infecting others.
- G. I understand the school system is not acting as my student's medical provider, this testing does or not replace treatment by my student's medical provider, and I assume complete and full responsibility to take appropriate action with regards to my student's test results. I agree I will seek medical advice, care and treatment from my student's medical provider if I have questions or

concerns, if their condition worsens. I understand I am financially responsible for any care my student receives from their healthcare provider.

- H. I understand that COVID-19 testing may create protected health information (PHI) and other personally identifiable information of the student, and such information will only be accessed, used, and disclosed in accordance with HIPAA and applicable law. Pursuant to 45 CFR 164.524(c)(3), I authorize and direct the testing provider to transmit such PHI to my student's school, the Massachusetts Department of Public Health, the Massachusetts Executive Office of Health and Human Services, and the testing laboratory. I further understand that PHI may be disclosed to the Executive Office of Health and Human Services and any other party, as authorized under HIPAA.
- I. I understand that participation in COVID-19 testing may require the school to disclose my student's identity, demographic, and contact information from education records to the Massachusetts Department of Public Health. Pursuant to FERPA, 34 CFR 99.30, I authorize my school to disclose such personally identifiable information (PII) as is required for my student to participate in COVID-19 testing.
- J. I understand that authorizing these COVID-19 tests for my student is optional and that I can refuse to give this authorization, in which case, my student will not be tested.
- K. I understand that I can change my mind and cancel this permission at any time, but that such cancellation is forward-looking only, and will not affect information previously released. To cancel this permission for COVID-19 testing, I need to contact the school nurse.

I, the undersigned, have been informed about the COVID-19 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 for my student. My undersigned signature indicates that I have read, understand, and agree to the contents of this document, and that I have full authority to act on behalf of the student named above.

Signature of Parent/Guardian:

Date:

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