Student Consent Form

Student consent form for follow-up diagnostic testing, when indicated

TO BE COMPLETED BY PARENT / GUARDIAN			
Parent/Guardian Information			
In the event of a positive result from diagnostic testing, you will be notified via phone or email.			
Parent/Guardian Name:			
Parent/Guardian Cell/Mobile #:			
Parent/Guardian Email Address:			
Child/Student Information			
Child/Student Name:			
Grade Level:		Classroom (if applicable):	
Date of Birth: *(MM/DD/YYYY)*		Age:	
Has the student listed above been diagnosed with COVID-19 in the past 90days?	○ **Yes,** my student has tested positive for COVID-19 in the past 90 days (note: individuals who have tested positive for COVID-19in the past 90 days should not participate in pooled testing). ○ **No**, my student has **not** tested positive for COVID-19 in the past 90 days.		

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

A. I authorize my student to participate in the diagnostic COVID-19 testing program to include collection of specimens during school hours by school personnel and subsequent analysis by Atlas Genomics.

B. I authorize collection of samples for any applicable individual diagnostic tests from my student, including rapid testing and/or PCR molecular tests, as indicated.

C. I understand that I will be notified about the results of any individual diagnostic test for COVID-19 performed on my student, when follow-up testing is indicated.

D. I understand that false positive or false negative COVID-19 test result may occur in pooled or individualtests. 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.

E. 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 neitherthe test administrator nor St. John Catholic School, nor any of

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

its trustees, officers, employees, ororganization sponsors are liable for any accident or injuries that may occur from my student's participation in the pooled testing program.

F. 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 amask or face covering as directed by school or public health officials.

G. 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 take appropriate action with regards to my student's test results and Iagree 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 caremy student receives from their healthcare provider.

H. I understand that participation in pooled testing may require the school to disclose my student's identity, demographic, and contact information from education records to the testing provider(s). Pursuant to FERPA, 34 CFR 99.30, I authorize the school to disclose such personally identifiable information (PII) as is required for my student to participate in rapid testing, pooled testing, and any indicated follow-up testing.

I. I understand that follow-up diagnostic testing requires submission of protected health information (PHI)and other personally identifiable information of the student. Pursuant to 45 CFR 164.524(c)(3), I authorizeand direct the testing provider to transmit such PHI to my student's school, the Washington State Department of Health, and Atlas Genomics, LLC. 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.

J. I understand that authorizing COVID-19 testing for my student is optional and that I may refuse to give thisauthorization, in which case, my student will not be tested.

K. 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 authorizationfor COVID-19 testing, I must contact my student's school.

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 testing for my student.

Signature of Parent/ Guardian **Date**