Addison Central School District Consent for COVID-19 Testing (Rapid & Screening Test)

The Addison Central School District (the "District") is seeking your consent to test your child for COVID-19 infection. If you consent, your child may receive a free rapid antigen test and/or a self-administered saliva screening test for the COVID-19 virus that will be administered by one of our District nurses. A rapid COVID-19 test will involve inserting a small swab, similar to a Q-Tip, into the front of the nose. A Screening test is a self-administered saliva cheek swab inside the mouth. We will notify you if your child tests positive for COVID-19. Any students who test positive will be sent home and must be kept at home until meeting Steuben County Health Department criteria to return to school. Please contact your child's doctor immediately to review the test results should your child test positive for COVID-19.

Student Information

Student Name:	
Student Date of Birth:	
School Student Attends:	
Student Grade:	

Parent Information

Parent Name:	
Parent Phone Number:	
Parent Mailing Address:	
Parent Email Address:	

The law requires and/or allows some information about your child to be shared with Steuben County and New York State Public Health Agencies. This includes notifying the Steuben County Health Department about the COVID-19 results of each student who is tested, including the student's name, date of birth, race, ethnicity, gender, address, phone number, and result of the COVID-19 test. By signing below, I attest that:

- I have signed this form freely and voluntarily, and I am legally authorized to make decisions for the child named above.
- I authorize the Addison Central School District to test my child for COVID-19 infection.
- I understand that my child may be tested at multiple times during the 2021-2022 school year.
- I understand that this consent form will be valid through June 30, 2022, unless I revoke such consent in writing.
- I authorize my child's test results and other information to be disclosed to any governmental entity as may be required or permitted by law.
- I acknowledge that a positive test result will require my child to be sent home from school and remain at home until he/she meets the criteria to return to school according to the Steuben County Health Department.
- I understand that this testing does not replace treatment by my child's medical provider, and I assume complete and full responsibility to take appropriate action regarding my child's test results. I agree that I will seek medical advice, care, and treatment for my child from his/her medical provider if I have questions or concerns or if my child becomes ill or my child's condition worsens.
- I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

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Signature of Parent/Guardian Date

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Print Name