Caregiver Consent for Child COVID-19 Symptomatic Testing

The Ithaca City School District will conduct a COVID-19 symptomatic testing program during the 2023-2024 academic year for students who become unwell at school. Testing may be contingent upon the availability of antigen test kits received from state and local agencies. Sampling requires a swab just inside the nose. Testing is provided to participating students at no cost.

Student participation in the testing program is voluntary, and the Ithaca City School District is requesting that parents/caregivers complete a consent form as indicated below to allow their children to be tested for COVID-19 at school. We will not test your child without your consent.

STUDENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____/_____/_____ Student ID # (if unknown, leave blank): _____

School: _____ Grade (PreK-12): _____

AUTHORIZATION

Check the box below to authorize the Ithaca City School District to test your child for COVID-19.

☐ I authorize Ithaca City School District to test my child for COVID-19 for the purposes of symptomatic testing should my child become unwell while at school.

Test results will be provided by the school nurse. Positive test results are reported to the New York State Department of Health.

ATTESTATION

By signing below, I attest to the following:

- I understand my child's test results may be shared with the New York State Department of Health or any other governmental entity the law requires. The release of any legally privileged and confidential records (e.g. educational and/or medical records) will be in accordance with applicable privacy protection laws, including the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA).

(continued on next page)

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- I assume complete and full responsibility to take appropriate action with regard to my child's test results. I acknowledge a positive test result is an indication my child must self-isolate and wear a mask or face covering as directed to avoid infecting others. I understand, as with any medical test, this COVID-19 test has the potential for false positive (test is positive but my child does not have the infection) or false negative (test is negative but my child has the infection) results. I agree to seek medical advice, care, and treatment from my healthcare provider if I have questions or concerns or if my child's condition worsens. I understand the testing unit is not acting as a healthcare provider, and this testing does not replace treatment by a healthcare provider.
- I understand the test purpose, procedures, possible benefits and risks, and I can request a copy of this consent form. I can ask questions before I sign this consent form, and I understand I can ask additional questions at any time.
- I understand there will be no out of pocket charge for the tests, the costs will be covered by CARES Act funding.
- I understand I can contact my child's school at any time to revoke my consent and end my child's participation in the testing program.

Signature: _____ Date: _____/_____/_____

Email: _____ Phone: (_____) _____-_____

Relationship to child (check one):

☐ Parent
☐ Legal Guardian
☐ Person possessing lawful order of custody
☐ Person in parental relation