

QPS District #172 STUDENT/STAFF CONSENT FORM FOR OPTIONAL COVID-19 TESTING

QPS District #172 takes the health and safety of our students and their families very seriously. As such, in addition to steps to screen for the virus and prevent its spread on a campus, we are adding a voluntary K-12 COVID-19 testing program for students. This program uses Abbott Laboratories BinaxNOW tests provided by the federal government. We will only test with your consent. If you are willing to provide consent for us to administer this test on your child or yourself (if aged 18 or older), please fill out this form.

What is the test?

If your child is symptomatic, if you consent, your child will receive a free BinaxNOW rapid test for the COVID-19 virus. Collecting a specimen for testing involves using a swab, similar to a Q-Tip, placed inside the tip of the nose. The school nurse, who has been trained to use this test, will collect the specimen. Test results will be made available to the parent/guardian who signs this form below. The results will be verbalized by phone call or sent by text message following the test. This program is **entirely optional** for students, although we hope you choose to have the test to keep our schools as healthy & safe as possible. The tests are being offered in addition to existing safety protocols such as mask-wearing, social distancing, and frequent disinfection of surfaces.

What should I do when I receive my child's test results?

If your child or you (if student age 18 or older) tests positive for the virus, your child will need to be picked up from school immediately. We ask that you keep your child home until the infection period has ended (at least 10 days from the date symptoms first appear). If your child's test results are negative, the virus was not found in the specimen tested and your child may continue to attend school without interruption. If your child tests negative but has symptoms of COVID-19, or if you have concerns about your child's exposure to COVID-19, you should call your child's doctor, a licensed medical authority, or your local health department.

Known Symptoms:

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear **2-14 days after exposure to the virus**. People with these symptoms may have COVID-19:

- Feeling feverish or a measured temperature greater than or equal to 100.0 degrees Fahrenheit
- Loss of taste or smell
- Cough
- Difficulty breathing
- Shortness of breath
- Fatigue
- Headache
- Chills
- Sore throat
- Shaking or exaggerated shivering
- Significant muscle pain or ache
- Diarrhea
- Vomiting

This list does not include all possible symptoms.

Disclaimer:

While we realize precautions will be taken for the safety of students, please understand that neither the test administrator nor the Quincy Public School District, nor any of its trustees, officers, employees, or organization sponsors are liable for any accident or injuries that may occur to your child or yourself (if 18 or older), as a result of agreeing to the test.

TO BE COMPLETED BY PARENT, GUARDIAN OR ADULT STUDENT/STAFF

STAFF/Parent/Guardian Information

You will be notified with test results either via cell phone or email, or both.

Parent/Guardian Print Name:				
Parent/Guardian Cell/Mobile #: <i>Note: results will be texted to this cell #</i>				
Parent/Guardian Email Address:				
Student/Staff Print Name:				
Street Address:		City:		State:
Zip Code:		County:		
School:		Grade Level:		
Date of Birth: <i>(MM/DD/YYYY)</i>		Age:		

CONSENT

By signing below, I attest that:

- A. I authorize the school system to conduct collection and testing of my child or me(18 or older) for COVID-19 by nasal swab.
- B. I acknowledge that a positive test result is an indication that my child or me (if age 18 or older), must self-isolate and also continue wearing a mask or face covering as directed in an effort to avoid infecting others.
- C. I understand the school system is not acting as my child’s medical provider, this testing does not replace treatment by my child’s medical provider, and I assume complete and full responsibility to take appropriate action with regards to my child’s test results. I agree I will seek medical advice, care and treatment from my child’s medical provider if I have questions or concerns, or if their condition worsens.
- D. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

I, the undersigned, have been informed about the 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 of my child or myself for COVID-19.

Signature of Parent/ Guardian:		Date:
Signature of Student: <i>(if age 18 or over or otherwise authorized to consent)</i>		Date:
Signature of Staff:		Date: