

## CONSENT FORM FOR THE NJ TEST TO STAY PROGRAM

### Parent/Guardian Information

<b>Parent/Guardian Print Name:</b>	
<b>Parent/Guardian Cell #:</b> <small>Note: results will be texted to this cell #</small>	
<b>Parent/Guardian E-Mail Address:</b>	

### Child/Student Information

<b>Child/Student Print Name:</b>					
<b>Classroom/Grade:</b>					
<b>Date of Birth:</b> <small>(MM/DD/YYYY)</small>					
<b>Address:</b>		<b>City:</b>		<b>Zip Code:</b>	

<b>Consent Opt Out:</b>	<input type="checkbox"/> <b>Yes</b> , I provide consent for my student to participate in COVID-19 testing <i>(please read and sign form below)</i> <input type="checkbox"/> <b>No</b> , I do not provide consent for my student to participate in COVID-19 testing. <i>(No further action needed)</i>
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## 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 an individual test (e.g. individual antigen or PCR test). By signing this form, I am consenting to any of the following testing situations for my child.
  - i. Individual testing on symptomatic individuals: when individuals display symptoms while in the school setting.
  - ii. Individual testing on close contacts (Test and Stay): for asymptomatic close contacts to be tested every other day for at least five (5) days from the first day of exposure, with individuals testing negative being allowed to remain at school.
- B. I understand that all sample types will be non-invasive, short nasal swabs or saliva samples.
- C. I understand that I will be notified about the results POSITIVE or NEGATIVE of any individual test for COVID-19 performed on my child.
- 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 and testing in the event the student develops symptoms of COVID-19.
- E. I understand that the staff administering COVID-19 tests are medical professionals. I agree that the staff administering the test are not held liable for any accident or injuries that may occur from participation in the NJ 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. Dates of isolation will be assigned by the school nurses.

G. I understand regardless of the test results, students must adhere to all COVID-19 school safety guidance, including mask-wearing and social distancing, and follow school protocols in the event the student develops symptoms of COVID-19.

H. I understand the school system is not acting as my student's medical provider, this testing does 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, or if their condition worsens. I understand I am financially responsible for any care my student receives from their healthcare provider.

I. 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 the applicable laws of New Jersey.

J. I understand that participation in COVID-19 testing may require the school to disclose my student's identity, demographic, and contact information when reporting results.

K. 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.

L. 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 to inform in writing.

I, the undersigned, have read and understand the information in this consent form about the test purpose, procedures, possible benefits and risks. 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 COVID-19 testing for my student. This permission will be in effect from the date of my signature and at any time my child is enrolled in the NJ Test to Stay Program unless I terminate this authorization in writing. 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 I already permitted to be released. To cancel this permission for in school COVID-19 testing, please contact the school nurse.

**Signature of Parent/ Guardian:**

**Date:**