INFORMED CONSENT AND RELEASE FOR COVID-19 DIAGNOSTIC TESTING

(BY SIGNING THIS DOCUMENT, YOU WILL WAIVE CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE. PLEASE READ CAREFULLY!)

Authorization and Consent for Covid-19 Diagnostic Testing and Disclosure of Results:

1. I certify that I am at least eighteen years of age and, if applicable, am the adult parent or guardian of ____________________________, a child under the age of eighteen years.
   (printed name of minor child)

2. I, personally and on behalf of my minor child, voluntarily consent to and authorize Lake County School District R-1, by and through its employees or agents, to conduct collection, testing, and analysis of a COVID-19 diagnostic test of me/my child. I acknowledge and understand that my/my child's COVID-19 diagnostic test will require the collection of an appropriate sample through a nasopharyngeal swab, oral swab, or other collection procedures ordered by an authorized medical provider or public health official.

3. I understand that there are risks and benefits associated with undergoing a diagnostic test for COVID-19 and there may be a potential for false positive or false negative test results. I acknowledge that a positive test result is an indication that I/my child must self-isolate and/or wear a mask or face covering as directed in an effort to avoid infecting others, and that I/my child may be held out of school until it is deemed safe for me/my child to return.

4. By voluntarily undergoing the COVID-19 diagnostic test, I am also voluntarily authorizing the disclosure of my/my child's test results to the Lake County Public Health Department. I acknowledge that Lake County School District R-1 will maintain my/my child's test results and that any testing information disclosed may be subject to redisclosure as required by law. I understand that my/my child's test results will be used to address the health and safety of students, staff, and visitors through medical surveillance of COVID-19 cases at all schools.

5. I acknowledge that neither Lake County School District R-1 nor its employees or agents administering my/my child's diagnostic test are acting as my/my child's medical provider and that testing does not replace treatment from a medical provider. I assume complete and full responsibility to take appropriate action with regards to my/my child's test results.

Release:

I agree, personally and on behalf of my minor child named above, to release, discharge, and hold harmless, Lake County School District R-1, including, without limitation, its board members, officers, directors, employees, representatives, agents, and authorized volunteers from any and all claims, losses, liabilities, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to my/my child's COVID-19 diagnostic test.

[SIGNATURE PAGE ON OTHER SIDE]

By signing this Informed Consent and Release for COVID-19 Diagnostic Testing, I acknowledge that I have read, understand, and agree to the statements contained within this Informed Consent and Release form. I have been informed about the purpose of the COVID-19 diagnostic test, procedures to be performed, and the potential risks and benefits of the test. I have been given an adequate opportunity to read this form and to ask questions before proceeding or allowing my child to proceed with the COVID-19 diagnostic test. I voluntarily consent to undergo or to allow my minor child to undergo diagnostic testing for COVID-19. The authorization to disclose diagnostic testing results is effective immediately. I have a right to request and receive a copy of this Informed Consent and Release for COVID-19 Diagnostic Testing.

______________________________ ______________________________

(Signature) (Printed Name)

____

(Date)

______________________________ ______________________________

(Signature of Parent/Legal Guardian) (Printed Name)

____

(Date)

______________________________ ______________________________

(Print Minor's Name - *Last, First Middle Initial*) (Minor's Date of Birth - *MM/DD/YYYY*)

____

(Relationship to Minor Child)

Abbott BinaxNOW
COVID-19 Test Information

All information collected must be reported to the Colorado Department of Public Health and Environment at https://covidbinax.colorado.gov.

Patient Information

First name (required)

____

Last name (required)

____

Date of Birth (required)

_____ /_____ / ________

MM, DD, YYYY

Sex (select one, required)

- ◯ Male
- ◯ Female
- ◯ Female to Male
- ◯ Male to Female
- ◯ Unknown

Race (select all that apply)

- ☐ American Indian or Alaskan native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other ______________________
- ☐ Prefer not to answer

Ethnicity (select one)

- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Prefer not to answer

Home address 1 (required)

____

Home address 2 (apartment, suite, etc.)

____

City (required)

____

Zip code (required)

____

State (required)

____

Phone number (required)

____

Test Information (Official use only)

Test ID from label (required)

____

Collection date (required MM, DD, YYYY)

_____ /_____ / ________

Result (circle one): Positive Negative Inconclusive

Abbott BinaxNOW

COVID-19 Test Information