STUDENT CONSENT FORM FOR COVID-19 TESTING & RELEASE OF RECORDS

What is this form?

We are seeking your consent to test your child for COVID-19 infection. The Proviso Township High Schools District 209 has partnered with the University of Illinois to test School District students, teachers, staff members and others for COVID-19 infection. This form provides individual consent and authorization for the test to be conducted.

How often will your child be tested?

Students may be tested one time per week.

What is the test?

If you consent, your child will receive a free diagnostic test for the COVID-19 virus conducted by collecting saliva (spit).

How will I know if my child tests positive?

You will receive access to your child's test results via an online platform. We will send you details about the online platform in a future correspondence. The School District will also receive the results of your child's test and may/will notify you of any positive result.

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

If your child's test results are positive, please contact your child's doctor immediately to review the test results and discuss next steps. You may not send your child back to school until health and safety quarantine protocols have been completed.

If your child's test results are negative, this means that the COVID-19 virus was not detected in your child's saliva (spit).

Tests sometimes produce incorrect negative results called "false negatives" in people who have COVID-19. 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.

By allowing your child to take this test, you agree to release, defend and indemnify the District and its Testing Partners from any and all claims that you or your child may have regarding the accuracy of the test and any actions that you or your child take based upon the delivered results of the test.

Who will receive my child's test results? In addition to you receiving your child's test results, the School District and the Illinois Department of Public Health ("IDPH") will also receive your child's test results, consistent with IDPH guidance and the Illinois Control of Communicable Disease Code.

TO BE COMPLETED BY PARENT/GUARDIAN

Parent/Guardian Information All sections required – please print clearly	
Parent/Guardian Print Name:	
Parent/Guardian Home Address:	
Parent/Guardian Tel./Mobile #:	
Parent/Guardian Email Address:	
Best way to contact you:	
Child/Student Information All sections required – please print clearly	
Child/Student Print Name:	
Child/Student Date of Birth:	
Child/Student School:	
Child/Student Home Address:	

Ethnicity		Hispanic or Latino				Not Hispanic or Latino						
Race 1		American Indian or Alaska Native		Asian		Black or African American		Native Hawaiian or Pacific Islander		White		Other
Race 2		American Indian or Alaska Native		Asian		Black or African American		Native Hawaiian or Pacific Islander		White		Other

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 consent for my child to be tested for COVID-19 infection.
- I understand that my child may be tested multiple times while the program is available, and that my child may participate in testing once per week.
- I understand that this consent form will be valid throughout the time the program is available, unless I notify the designated contact person from my child's school in writing that I revoke my consent.
- I understand that my child's test results and other information may be disclosed as permitted by law.
- I understand that if I am a student age 18 or older, or if I may otherwise legally consent to my own health care, any references to "my child" refer to me and I may sign this form on my own behalf.

Signature of Parent/Guardian (if child is under age 18):		Date:	
Signature of Student (if age 18 or over)		Date:	