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

We are seeking your consent to test your child for COVID-19 infection. The Edwardsville Community Unit School District No. 7 is utilizing the saliva-based COVID SHIELD test developed by the University of Illinois Urbana-Champaign (UIUC) 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. If you do not consent to your child being tested for COVID-19, your child could be placed on a 14-day quarantine due to Covid-19 infection or exposure.

How often will your child be tested?

We are arranging to test all students for whom permission is provided at least 1 time per week. Testing students ensures the best protection and prevention from Covid-19.

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). There is no cost to you or to the School District.

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. <u>You may not send your child back to school until health and safety quarantine protocols have been completed</u>.

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.

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:	

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 using the University of Illinois' SHIELD Test, including the administration of the test by the District's Authorized Testing Partners.
- 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 through the 2021-2022 school year, unless I notify the designated contact person from my child's school in writing that I revoke my consent.
- I am fully aware that the Test being provided by Edwardsville Community Unit School District No. 7 may involve COVID-19 tests that have not undergone a full FDA approval process and instead have obtained emergency use authorization (EUA) or are registered and pending such processing and that the results could produce false positives or false negatives, or be administered in a way that otherwise produces inaccurate results.
- I am also fully aware that this is a non-diagnostic Test and that Edwardsville Community Unit School District No. 7 is not providing medical care or giving a medical diagnosis with the administration of the Test. I further understand and agree by my signature below that I should consult my doctor or go to an emergency room if my child or I have any questions, serious

symptoms, and/or to obtain medical advice from my own doctor as to the results of the Test.

- I acknowledge that the results of a SHIELD Test may not be sufficient to detect or rule out the possibility that my child has been exposed to or is infected with COVID-19 and that there is a potential for a false positive or false negative test result. SHIELD Tests do not replace treatment by my child's medical provider and I assume complete and full responsibility to take action with regard to my child's test results.
- I understand that my child's test results and other information may be disclosed as permitted by law.
- I acknowledge that the District may be required by law to disclose my student's test results to the Illinois Department of Public Health and the applicable local public health department. I voluntarily acknowledge and agree that the District may disclose my student's test results and associated information to appropriate county, state, or other governmental and regulatory entities as may be 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, anyreferences to "my child" refer to me and I may sign this form on my own behalf.
- I voluntarily agree to hereby release, discharge, and hold harmless, the Board, its members, employees, agents, officials, officers, insurers and/or attorneys, from any and all claims, liability, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to my child's COVID-19 Test or the disclosure of my child's COVID-19 Test Results.

_____	_____
Student Name (printed)	Parent Name (printed)
_____	_____
Student Signature Date (if age 18 or over)	Parent Signature Date (if child is under age 18)