USD PRE-CONSENT FORM FOR TEST TO STAY

What is this form?

We are seeking your consent to test your child for COVID-19 infection should our school experience a COVID-19 outbreak. For schools with >1,500 students and staff, the outbreak threshold is 1% of the school population. For schools with ≤1,500 students and staff, the outbreak threshold is 15 cases. By consenting to this test, your child would be allowed to return to school with a negative test result.

What is the test?

If you consent, your child will receive a free diagnostic test for the COVID-19 virus within two days of the school closure. Collecting a specimen for testing involves a nasal swab.

How will I know if my child tests positive?

Positive rapid test results will be communicated the same day of the test by phone.

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

If your child's test results are negative and your child has no symptoms, they may return to school on the next in person learning day. If your child's test results are positive, please contact your child's doctor immediately to review the test results and discuss what you should do next. If your child's test results are negative, this means that the virus was not detected in your child's specimen. 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.

TO BE COMPLETED BY PARENT, GUARDIAN, OR ADULT STUDENT

Parent/Guardian Information

Parent/Guardian Print Name:			
Mailing Address:			
Parent/Guardian Tel./Mobile #:			
Parent/Guardian Email address:			
	Check your email within 24 hours of the test for negative results. Individuals testing positive will receive a phone call on the same day of testing.		
Student Print Name			
Student School Lunch number		Child/Student Date of Birth:	
Student Ethnicity:		Student Race:	☐ Hispanic or Latino ☐ Not Hispanic or Latino
Child/Student School:		Child/Student Address:	

NOTIFICATION OF INFORMATION SHARING

The law allows some information about your child to be shared with and among certain Utah State agencies and their contracted service providers, including those listed below. This information will be shared only for public health purposes, which may include notifying close contacts of your child if they have been exposed to COVID-19 and taking other steps to prevent the further spread of COVID-19 in your school community. Information about your child that may be shared with these agencies and service providers conducting COVID-19 Testing includes your child's name and COVID-19 test results, date of birth/age, gender, race/ethnicity, school name(s), teacher(s), classroom/cohort/pod, enrollment and attendance history, and after school or other program participation, names of other family members or guardians, address, telephone, mobile number, and email address. Sharing of information about your child will **only** be done so in accordance with applicable laws protecting student privacy and the security of your child's data.

- School District Where Student Attends
- Utah Department of Health

CONSENT

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 if I revoke my consent or refuse to sign, my child may be required to continue their education via remote learning.
- I understand my child's test results and other information may be disclosed as permitted by law.
- I understand if I am a student age 18 or older, or may otherwise legally consent for my own health care, references to "my child" refer to me and I may sign this form on my own behalf.
- I understand if symptoms develop, testing and/or treatment will not be provided through the district, but through my medical provider.
- I understand if my child is not able to cooperate due to the discomfort of the test, I will be referred to my medical provider or clinic for testing at my cost or the cost of my insurance.

Signature of Parent/ Guardian* (if child is under age 18)		Date
Signature of Student (if age 18 or over or otherwise authorized to consent)		Date

For Nursing Staff Only

○ Positive ○ Negative