

**STUDENT CONSENT FORM FOR OPTIONAL COVID-19 POOLED AND FOLLOW-UP TESTING
PROJECT BEACON OR CIC HEALTH**

TO BE COMPLETED BY PARENT / GUARDIAN

Parent/Guardian Information

You will be not be notified with pooled test results, but will be notified of individual follow-up test results either via phone or email.

Parent/Guardian Print Name:	
Parent/Guardian Cell/Mobile #:	
Parent/Guardian Email Address:	

Child/Student Information

Child/Student Print Name:			
Grade Level:		Classroom (if applicable):	
Date of Birth: <i>(MM/DD/YYYY)</i>		Age:	
Has the student listed above been diagnosed with COVID-19 in the past 90 days?	<input type="checkbox"/> Yes , my student has tested positive for COVID-19 in the past 90 days (note: individuals who have tested positive for COVID-19 in the past 90 days should not participate in pooled testing). <input type="checkbox"/> No , my student has not tested positive for COVID-19 in the past 90 days.		

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 the collection and testing of a weekly pooled COVID-19 test on my student during school hours, in addition to any necessary individual diagnostic follow-up tests on my student (including Abbott BinaxNOW rapid antigen tests and PCR/molecular tests). I understand that all sample types will be non-invasive, short nasal swabs.
- B. I understand that pooled testing does not yield individual results for each member of a pool, and that my student’s individual results within a pooled test cannot be shared with me. However, I understand and agree that my student’s personal health information and personally identifiable information from education records may be entered into the testing provider’s technology platform to assist with tracking pooled testing and identifying individuals in need of follow-up testing.
- C. I understand that I will be notified about the results of any individual diagnostic “follow-up” test for COVID-19 performed on my student.
- D. I understand that there is the potential for a false positive or false negative COVID-19 test result for pooled or individual tests. Given the potential for a false negative, I understand that my student should continue to follow all COVID-19 safety guidance, including mask-wearing and social distancing, and follow school protocols for isolating and testing in the event the student develops symptoms of COVID-19.
- E. I understand that staff administering pooled testing and follow-up testing have received training on safe and proper test administration. I agree that neither the test administrator nor the Boston Public

Schools, nor any of its trustees, officers, employees, or organization sponsors are liable for any accident or injuries that may occur from participation in the pooled testing program.

- F. I understand that my student **must** stay home if feeling unwell. I acknowledge that a positive individual follow-up 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.
- G. 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.
- H. I understand that follow-up testing may create protected health information (PHI) and other personally identifiable information of the student. Pursuant to 45 CFR 164.524(c)(3), I authorize and direct the testing provider to transmit such PHI to my student’s school, the Department of Public Health, and the testing laboratory. I further understand that PHI may be disclosed to the Executive Office of Health and Human Services and any other party, as authorized under HIPAA.
- I. I understand that participation in pooled testing may require the school to disclose my student’s identity, demographic, and contact information from education records to the testing provider and, for follow-up tests, will require the school to disclose my student’s my student’s identity, demographic, and contact information from education records to the Department of Public Health. Pursuant to FERPA, 34 CFR 99.30, I authorize my school to disclose such personally identifiable information (PII) as is required for my student to participate in pooled and follow-up testing.
- J. 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.
- K. 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 COVID-19 testing, I need to contact my student’s school.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent. 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 testing for COVID-19 for my student.

Signature of Parent/ Guardian:		Date:
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