School or Building: _____

USD 261 -Consent to COVID-19 Test

Name of Staff or Student: _____ Date of Birth: _____

Street Address: _____

Apt/Lot #: _____

City: _____

State: _____ Zip: _____

Phone Number: _____

Race: ☐ Asian ☐ Black ☐ American Indian or Alaskan Native ☐ Other ☐ White

Ethnicity: Hispanic? ☐ Yes ☐ No Gender: ☐ Male ☐ Female ☐ Other

Please carefully read and provide acknowledgment of the following informed consent:

a. I authorize a COVID-19 testing administrator associated with the school district, local health department or state health department to conduct collection and testing for COVID-19 through a saliva sample and/or nasal swab collection as ordered by an authorized medical provider or public health official.

b. I authorize my test result, or the test result of my child if my child is under the age of 18 years, to be disclosed to the county, state, or to any other governmental entity as may be required by law.

c. I give permission for the Sedgwick County Health Department and my school district to contact me using non-secure methods (e-mail and phone calls) regarding this COVID-19 test result, and I understand the risks involved.

d. I acknowledge that a positive test result is notice that the person tested must self-isolate, avoid others and/or remain in his/her home in compliance with the health department.

e. I understand that if a PCR test is completed, I will need to read Wichita State University's consent and release of information. A verbal consent will need to be given prior to the PCR test.

_____

Signature of Parent/Guardian or Staff Member Date

_____

Printed Name of Parent/Guardian or Staff Member

For Health Staff Only - If PCR Test is Performed

☐ I confirm that WSU's consent was provided and verbal permission was given.