

Arlington Heights School District No. 25
SHIELD RAPID rtPCR COVID-19 Testing Consent Form

STUDENT

This consent provides Arlington Heights School District No. 25, with your permission, to perform a “SHIELD Illinois Rapid rtPCR” test (“Test”), as needed, as part of our COVID-19 Safety Protocols. The purpose of providing the Test is based on the District’s need to maintain a safe environment for employees and students, and other essential persons with whom you may have come into contact.

In consideration for receiving the opportunity to participate in **COVID-19 testing** (hereinafter “Testing”), which is provided by Arlington Heights School District No. 25, I hereby release, waive, discharge, covenant not to sue, and agree to hold harmless for any and all purposes District 25 and their healthcare staff, other staff members, administrators, board members, servants, agents, volunteers, and/or any other employees (herein referred to as “Indemnitees”) from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney’s fees and expenses, that may be sustained by me while participating in Testing, traveling to and from the Testing, and/or on the premises owned or leased by Indemnitees.

I am fully aware that the Testing provided by the District 25 may involve COVID-19 tests that have not gone through a full FDA approval process and instead obtained emergency use authorization (EUA) or registered and are 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 the organization is not providing medical care or giving a medical diagnosis with Testing and that ***I should consult my doctor or go to an emergency room if I have any questions, serious symptoms, and/or to obtain medical advice from my own doctor as to the results of the Testing.***

Pursuant to the District 25 COVID-19 testing program, you are eligible, on an optional basis, for a test up to 1x time per week on a regular basis. Should you become eligible for the “Test to Stay” strategy to remain in school rather than quarantine, you may choose to be tested more frequently as required by the strategy.

You will receive access to your child’s test results via an online platform which we will separately send you information about in future correspondence. The School District may also receive results of your child’s test and will notify you separately of any positive result. If your child’s test results are positive, please contact your child’s doctor immediately to review the test results and discuss next steps. Exclusions/guidelines for return will be communicated to you pursuant to the ISBE/IDPH/Cook County Health Department Exclusion Procedures and Protocols. If your child’s test results are negative, this means that the COVID-19 virus was not detected in your child’s saliva (spit). 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.

By signing below, I :

- (1) hereby waive my student’s rights regarding protected health information under HIPAA (specific only to the SHIELD Illinois Rapid rtPCR), FERPA, and/or ISSRA, as applicable and to the extent necessary to complete the testing and to allow District 25 and/or SHIELD Illinois to provide the results (whether positive or negative) of the Test to local and state

public health authorities (which may result in further direct communication from those entities to me for further follow-up and contact tracing). Protected health information will not be reused or disclosed by the organization to any person or entity other than above, except as required by law.

- (2) voluntarily acknowledge that you have the right to consult with your Doctor prior to testing of your Student;
- (3) voluntarily acknowledge that you have been provided an opportunity to ask questions before proceeding with a COVID-19 Test;
- (4) voluntarily acknowledge that you understand that if you do not wish to continue with the COVID-19 Test that you may decline and not test, but that if you do not test you will (1) abide by the ISBE/IDPH/Cook County Health Department Exclusion Procedures and Protocols, and/or (2) abide by all District based mitigation efforts;
- (5) voluntarily consent to this Test for the purpose of determining whether your child has COVID-19;
- (6) voluntarily consent to the disclosure of Test results to the District and Testing Administrator which will be maintained as a medical record in the same manner that the District currently maintains other medical records such as immunizations and physicals;
- (7) voluntarily agree to cooperate with the District in any contract tracing procedures and/or protocols as required by ISBE/IDPH/Cook County Health Department, if applicable; and
- (8) 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 COVID-19 Test or the disclosure of my COVID-19 Test Results in accordance herein.

Student First Name:	Student Middle Initial:	Student Last Name:
Student Date of Birth:	Student Sex: Male/ Female/ Unknown	Student Ethnicity: Hispanic/ Non-Hispanic/ Unknown
Student 1st Race: White / African American or Black / Native American / Asian - Pacific Islander / Other / Unknown		
Student 2nd Race: Not Applicable / White / African American or Black / Native American / Asian - Pacific Islander / Other / Unknown		
Student Mailing Address:		
Phone Number:	Parent/ Guardian Name:	
Parent/ Guardian Signature:		Date: