Santa Fe Trail USD #434 Consent for COVID-19 Testing

NAME:

Date of Birth:

Please carefully read and provide written acknowledgement of the following informed consent:

*I authorize a COVID-19 testing administrator associated with Santa Fe Trail School District, local health department or state health department to conduct collection and testing for COVID-19 through a nasal swab collection as deemed appropriate for the purpose of

- ***They are exhibiting symptoms that can be associated with the COVID-19 virus.***
- ***They are considered a close contact and desires to stay and learn.***
- ***They are considered a close contact and desire to stay and play.***

*I authorize a testing administrator associated with Santa Fe Trail School District, local health department or state health department to conduct collection for COVID-19/Flu A and B when symptoms align with both illnesses with a nasal swab collection.
*I understand by signing this document that I am giving permission for diagnostic screening to be conducted as needed during the 2024-2025 school year or until I have notified the school, in writing, that my consent is being withdrawn.
*I authorize my test result, or the test result of my child if my child is under the age of 18 years of age, to be disclosed to the county, state, or to any other governmental entity as may be required by law.
*I understand that, as with any medical test, there is a potential for a false positive or false negative COVID-19 test result.
*I give permission for the Osage County Health Department and my school district to contact me using non-secure methods (email or phone) regarding this COVID-10 test result, and I understand the risks involved.
*I understand my student may be asymptomatic and wear a mask during their quarantine period to participate in test to stay and learn and test to play

Authorization and Consent for COVID-19 Diagnostic Testing:

- ***I voluntarily consent and authorize the Kansas Department of Health and Environment (KDHE) to conduct collection, testing and analysis for the purposes of a COVID-19 diagnostic test.***
- ***I acknowledge and understand that my COVID-19 diagnostic test will require the collection of an appropriate sample through a nasopharyngeal swab collection process.***
- ***I understand that there are risks and benefits associated with undergoing a diagnostic test for COVID-19 and there may be a potential for false positive or false negative test result.***
- ***I assume complete and full responsibility to take appropriate action with regards to my test results. Should I have questions or concerns regarding my results, or a worsening of my condition, I shall promptly seek advice and treatment from an appropriate medical provider. I understand that I am not creating a patient relationship with KDHE by participating in this testing. I understand the testing unit is not acting as my medical provider.***

Patient Rights and Privacy Practices

- ***I acknowledge and agree that KDHE may disclose my test results and associated information to appropriate country, state and other governmental and regulatory entities as may be permitted by law.***
- ***I acknowledge and agree that some limited personal information including my name and contact information may be shared with public health authorities if I am identified as a close contact to a positive case.***

Release

- ***To the fullest extent permitted by law, I hereby release, discharge and hold harmless, KDHE, including, without limitation, any its respective officers, directors, employees, representatives and agents from any and all claims, liability, and damages, of whatever kind of nature, arising out of or in connection with any act or omission relating to my COVID-19 diagnostic test or the disclosure of my COVID-19 test results.***

By signing, I acknowledge and agree that I have read, understand and agreed to the statements contained within this form. I have been informed about the purpose of the COVID-19 diagnostic test, procedures to be performed, and potential risks and benefits. I have been provided an opportunity to ask questions before proceeding with a COVID-19 diagnostic test and I understand that if I do not wish to continue with the collection, testing or analysis of a COVID-10 diagnostic test, I may decline to receive continued services. I have read the contents of this form in its entirety and voluntarily consent to undergo diagnostic testing for COVID-19.

Signature of Parent/Guardian: Date:

Date/Time/Name of Parent/Guardian contacted if phone consent given:

Nurse Signature:

Updated 5/16/2024