COVID-19 TESTING CONSENT FORM: Antigen & Molecular

THIS FORM MUST BE SIGNED PRIOR TO TESTING

PLEASE COMPLETE THE INFORMATION BELOW

Full, Legal name of Student or Staff (*First, Middle Initial, Last Name)* Please Print	**Name of School/ Grade**
ETHNICITY (CIRCLE ONE) Hispanic Non-Hispanic Other **GENDER (CIRCLE ONE)** Male Female Other	**RACE (CIRCLE ONE)** American Indian/Alaska Native Asian Black/ African American White Native Hawaiian/ Pacific Islander Other
Physical Address	**Birth Date (MM/DD/YYYY)** **Age**
Email Address	**Home Phone #** **Cell Phone #**

This consent form acknowledges my permission to participate in Molecular or Antigen COVID-19 testing. Please specify when you consent to testing: (check all that apply)

☐ COVID Exposure or Symptoms: I consent to COVID-19 testing if the individual named above is identified as close contact, opts into the "Test to Stay" protocol, or is displaying symptoms of COVID-19. I understand that these tests are run based off the availability of testing supplies and as KIBSD nurses and staff are able.

☐ Scheduled Asymptomatic Testing: I consent for the individual named above to participate in the weekly asymptomatic screening testing.

☐ Sports & Activity Asymptomatic Testing: I consent for the individual named above to participate in the recommended asymptomatic screening testing before or after travel or before large indoor gatherings/ events.

By signing this form for myself or on behalf of my student, I agree and attest to the following:

- I have signed this form freely and voluntarily.
- I authorize COVID-19 testing to be conducted via collection and testing through a nasal swab, as recommended by a medical provider, school nurse, or public health official.
- I understand and authorize the test results and other information to be disclosed as permitted by law.

- I acknowledge that a positive test result is an indication of a requirement to self-isolate and wear a mask or face covering as directed.

- I understand that the Kodiak Island Borough School District is not acting as a medical provider and that this testing does not replace treatment by a licensed medical professional.

- I assume complete and full responsibility to take appropriate action when I receive the test results either for myself or for my student. I agree that I will seek medical advice, care and treatment for myself and my student.

- I understand that, as with any medical test, there is the potential for a false positive or a false negative COVID-19 test result.

- I understand that there will be no out-of-pocket cost for this testing.

- I understand that this consent form will be valid through July 1st, 2022, unless I notify the District, in writing, that I revoke my consent.

- To the fullest extent permitted by law, I agree to defend, indemnify and hold harmless Kodiak Island Borough School District, its elected and appointed officials, employees, and volunteers against any and all liabilities, claims, demands, lawsuits, or losses, including costs and attorney fees incurred in defense thereof, arising out of or in any way connected or associated with the use of COVID-19 testing.

- Starting December 2021, you may choose to have COVID test results sent to the email listed above or a text message sent to the mobile phone number listed within a 24-48 hour period.

  ☐ I would like the COVID-19 test results sent to me via email.

  ☐ I would like the COVID-19 test results sent to me via text message.

  ☐ I would NOT like to be notified of the COVID-19 test results. (KIBSD staff will always promptly notify parents/ guardians via phone if an individual tests positive.)

Printed Name of Parent or Guardian	
Signature of Parent (or Student/ Staff if 18yrs or older)	Date