

BinaxNOW COVID-19 Voluntary Testing Consent & Acknowledgment Form for Students

Consolidated High School District 230 (“District”) seeks to maintain a safe environment for employees, students, and the school community in light of the COVID-19 outbreak. This consent provides the District with your permission to perform a COVID-19 test on your student and to release your student’s identifying information and test results to the Illinois Department of Public Health and the Cook County Health Department as described below.

Test Information

What is the BinaxNOW Test?

BinaxNOW is an antigen test that detects the presence of SARS-CoV-2, the virus that causes a COVID-19 infection, in about fifteen minutes. The specimen for the test is collected via a nasal swab. This test is completely voluntary and will not be administered unless this form is signed.

When Will Students Be Tested?

The District will administer the BinaxNOW test to students exhibiting symptoms of COVID-19, students who have been identified as close contacts, students enrolled in courses requiring weekly tests (i.e. internships, work programs) and whose parents/guardians have provided consent for testing. Do not send your student to school if he/she is exhibiting symptoms of COVID-19. Symptomatic students will be expected to quarantine consistent with the Illinois Department of Public Health and the Cook County Health Department’s guidance.

Who Will See My Student’s Test Results?

A District health care provider will conduct and interpret the BinaxNOW test. Test results will be available to any employees of the District with a legitimate educational interest, consistent with the *Illinois School Student Records Act*. Additionally, the District will share the following delineated information as described below:

- The District will share positive and negative test results, student name, student date of birth, sex, race, ethnicity, and student address with the Illinois Department of Public Health via electronic transmission using the Red Cap online reporting site. The purpose of this disclosure is to facilitate contact tracing and tracking of test usage.
- The District will share positive and negative test results, student name, student date of birth, sex, race, ethnicity, and student address with the Cook County Health Department via facsimile transmission. The purpose of this disclosure is to facilitate contact tracing and to assist the local health department in monitoring community transmission metrics.
- All positive and negative test results will also be shared with the student’s parent/guardian for the purpose of seeking additional medical treatment.

- The District will share positive and negative test results and student identifying information as otherwise permitted by law or guidance.

Acknowledgment of Risk

By signing below, I consent to my student's participation in the BinaxNOW testing program as described above. I knowingly and voluntarily assume and accept all risks associated with my student's participation in the BinaxNOW testing program. I understand that these risks include potential injury, illness, allergic reaction, and other potential risks of which I may not presently be aware.

I also acknowledge that the results of a BinaxNOW test may not be sufficient to detect or rule out the possibility that my child has been exposed to or is infected with COVID-19 and that there is a potential for a false positive or false negative COVID-19 test result. BinaxNOW tests do not replace treatment by my student's medical provider and I assume complete and full responsibility to take appropriate action with regard to my student's test results.

Waiver of Liability

In consideration of my student's participation in the BinaxNOW testing program at no cost, I (Parent/Guardian) on behalf of myself and my student, and my agents, representatives, assigns, heirs, successors, hereby waive, release, indemnify, hold harmless and covenant not to sue the District, and its Board of Education, individual Board members, employees, agents, representatives, volunteers, insurers, and assigns, and each and every one of them, from and against any and all claims, suits, liabilities, and causes of action, whether known or unknown, past, present, or future, including but not limited to any and all costs, expenses, attorney's fees, by reason of injury, illness, allergic reaction, property damage, loss, or death, arising out of, in connection with, or in any manner related to my student's participation in the BinaxNOW testing program, including any false test results and any resulting medical advice, course of treatment, or diagnoses, or related to the sharing of my student's test results or identifying information.

Consent and Signature

As parent/guardian of the student named below, I consent to allow the District to complete the BinaxNOW test on my student. I further authorize the District to share my student's identifying information and the results of the BinaxNOW test in the manner described above. I have read, understand, and agree to the terms herein, including the Acknowledgment of Risk and Waiver of Liability.

This COVID-19 Voluntary Testing Consent & Acknowledgment Form is effective upon signature and will be valid through June 30, 2023, unless revoked by providing written notice to the Associate Principal of PPS.

Signature of Parent/Guardian

Date

Print Parent/Guardian Name

Print Student Name

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