STUDENT CONSENT FORM FOR OPTIONAL COVID-19 TESTING

The Pampa ISD takes the health and safety of our students and their families very seriously. As such, in addition to steps to screen for the virus and prevent its spread on a campus, we are adding a voluntary K-12 COVID-19 testing program for students. This program uses Abbott Laboratories BinaxNOW tests provided by the federal government. We will only test with your consent. If you are willing to provide consent for us to administer this test on your child or yourself (if student age 18 or older), please fill out this form.

What is the test?

If your child is symptomatic or part of a group that is designated for testing, if you consent, your child will receive a free BinaxNOW rapid test for the COVID-19 virus . Collecting a specimen for testing involves using a swab, similar to a Q-Tip, placed inside the tip of the nose. A school staff member who has been trained to use this test will collect the specimen and a trained COVID-19 test administrator will oversee the process. Test results will be made available to the parent/guardian who signs this form below. The results will be sent by text message and email within 24 hours of the test. This program is **entirely optional** for students, although we hope you choose to have the test to keep our schools as healthy & safe as possible. The tests are being offered in addition to existing safety protocols such as mask-wearing, social distancing, and frequent disinfection of surfaces.

What should I do when I receive my child's test results?

If your child or you (if student age 18 or older) tests positive for the virus, we ask that you keep your child home until the infection period has ended (typically, after symptoms improve and at least 10 days from the date symptoms first appear) and your child is no longer contagious. If your child's test results are negative, the virus was not found in the specimen tested and your child may continue to attend school without interruption. In a small number of cases, tests sometimes produce incorrect results – showing negative results (called "false negatives") in people who have COVID-19 or showing positive results (called "false positives") in people who don't have COVID-19. If your child tests negative but has symptoms of COVID-19, or if you have concerns about your child's exposure to COVID-19, you should call your child's doctor, a licensed medical authority, or your local health department.

Known Symptoms:

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear **2-14 days after exposure to the virus.** People with these symptoms may have COVID-19:

- Feeling feverish or a measured temperature greater than or equal to 100.0 degrees Fahrenheit
- Loss of taste or smell
- Cough
- Difficulty breathing
- Shortness of breath
- Fatigue
- Headache
- Chills
- Sore throat
- Congestion or runny nose
- Shaking or exaggerated shivering
- Significant muscle pain or ache
- Diarrhea
- Nausea or vomiting

This list does not include all possible symptoms.

Disclaimer:

While we realize precautions will be taken for the safety of students, please understand that neither the test admnistrator nor the Pampa ISD, nor any of its trustees, officers, employees, or organization sponsors are liable for any accident or injuries that may occur to your child or yourself (if student age 18 or older), as a result of agreeing to the test.

TO BE COMPLETED BY PARENT, GUARDIAN OR ADULT STUDENT

Parent/Guardian Information

You will be notified with test results either via cell phone or email, or both.

Parent/Guardian Print Name:	
Parent/Guardian Cell/Mobile #: *Note: results will be texted to this cell #*	
Parent/Guardian Email Address:	

Child/Student Information

Child/Student Print Name:					
Driver's License #: *(if applicable)*					
Street Address:		**City:**		**State:**	
Zip Code:		**County:**			
School:			**Grade Level:**		
Date of Birth: *(MM/DD/YYYY)*			**Age:**		
Race/Ethnicity:	☐ Asian ☐ Hispanic ☐ Native American/Indigenous ☐ Black ☐ White ☐ Unknown		**Gender:**	☐ Male ☐ Female ☐ Other/Unknown	

CONSENT

By signing below, I attest that:

A. I authorize the school system to conduct collection and testing of my child or me (if student age 18 or older) for COVID-19 by nasal swab.
B. I acknowledge that a positive test result is an indication that my child or me (if student age 18 or older), must self-isolate and also continue wearing a mask or face covering as directed in an effort to avoid infecting others.
C. I understand the school system is not acting as my child's medical provider, this testing does not replace treatment by my child's medical provider, and I assume complete and full responsibility to take appropriate action with regards to my child's test results. I agree I will seek medical advice, care and treatment from my child's medical provider if I have questions or concerns, or if their condition worsens.
D. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19.

Signature of Parent/ Guardian:		**Date:**	
Signature of Student: *(if age 18 or over or otherwise authorized to consent)*		**Date:**	

PLEASE COMPLETE BACK SIDE OF FORM.

Please answer the following questions by circling and entering appropriate information:

Is this the first test (of any kind) the patient has had for COVID-19? No Yes

If NO, what type of test was taken before? (Please circle answer.)
Molecular
Antigen
Antibody
Unknown

If NO, what is the date of the last test? (Year and month only)
_____
(YYYY-MM)

Is the patient symptomatic? No Yes

If YES, date symptoms began: (year, month, day only)
_____
(YYYY-MM-DD)

Please circle the correct answer regarding symptoms that the patient has:

N/A	No	Yes	Fever over 100.4F?
N/A	No	Yes	Feeling feverish?
N/A	No	Yes	Chills?
N/A	No	Yes	Cough?
N/A	No	Yes	Shortness of breath?
N/A	No	Yes	Difficulty breathing?
N/A	No	Yes	Fatigue?
N/A	No	Yes	Muscle or body aches?
N/A	No	Yes	Headache
N/A	No	Yes	New loss of taste?
N/A	No	Yes	New loss of smell?
N/A	No	Yes	Sore Throat?
N/A	No	Yes	Nasal congestion?
N/A	No	Yes	Runny nose?
N/A	No	Yes	Nausea?
N/A	No	Yes	Vomiting?
N/A	No	Yes	Diarrhea?
N/A	No	Yes	Is the patient pregnant?