REQUIRED INFORMATION FOR TESTING

Student Name:
Student Date of Birth:
Sex: Male Female
Ethnicity: Hispanic Non-Hispanic Unknown
Race: White American Indian Native Hawaiian/Other Pacific Islander Black/African American Asian Other/Multiracial Unknown
Parent/Guardian Print Name:
Phone #
Home Address:
Parent/Guardian Email:

STAFF USE ONLY

Date Received: _____
Date Call Information Made: _____
By Who: _____
Notes:

Cypress Elementary School District #64 Consent for COVID-19 Testing

By signing below, I attest that:

- I consent freely and voluntarily to authorize Cypress School District 64 to conduct collection, testing and analysis for the purpose of COVID-19 diagnostic test to my student that will require collection of an appropriate sample from a trained licensed health care professional via either collection of saliva with SHIELD University of Illinois collection tubes or administer Abbot BinaxNOW through a nasal swab.
- I understand that there are risks and benefits associated with undergoing Diagnostic Test for COVID-19 and there may be potential for false positive or false negative test results. I assume complete and full responsibility to take actions with regards to my student's results. Should I have questions or concerns regarding my student's test results, or worsening of my student's condition, I shall promptly seek advice and treatment for my student from an appropriate medical provider.
- I acknowledge that the District/SHIELD University of Illinois is required by law to disclose my studen's test results to the Illinois Department of Public Health and applicable local public health department. I voluntarily acknowledge and agree that the District may disclose my student's test results and associated information to appropriate county, state, or other governmental and regulatory entities as may be permitted by law.
- I understand and acknowledge that the District/SHIELD University of Illinois my be protected from liability by the Public Readiness and Emergency Act (42 U.S.C 247d et seq) and or Local Governmental and Governmental Employees Tort Immunity Act (745 ILCS 10/1-101, et seq) for state or federal claims or lawsuits for injury including but not limited to, claims of negligence related to District administration of the Diagnostic Test to my students.
- I voluntarily acknowledge and agree that I have read, understand, and agree to the statements contained in 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 consent with the COVID 19 testing. I understand that this consent form will be valid through the 2021-2022 school year, unless I notify the designated contact person from my child's school in writing that I revoke my consent.
- I am legally authorized to make decisions for the student named above and I have read the contents of this form in its entirety and voluntarily consent for my Student to undergo the Diagnostic Testing for COVID-19.
- I understand that if I am a student age 18 or older, or may otherwise legally consent to my own health care, reference to " my student" refer to me and I may sign this form on my own behalf.

PLEASE INITIAL ALL THAT YOU CONSENT FOR

_____I consent to my student to be tested according to the District's screening schedule.

_____ I consent for my student to be tested if they are identified as a close contact within the school district and identified to quarantine. This will occur on days 1, 3, 5, and 7.

_____ I consent for my student if tested positive for the BinaxNOW test to have a follow up SHIELD Illinois Rapid rtPCR test.

Signature of Parent/Guardian (if child is under age 18):		Date:
Signature of Student (if age 18 or over)		Date: