WEST CENTRAL COMMUNITY UNIT SCHOOL DISTRICT #235
www.wc235.k12.il.us

1514 US Route 34
Biggsville, IL 61418
(309) 627-2371

Test for: _____ Staff _____ Student _____ Other Test No. _____ **This Section for Office Use Only**

Test for: Last Name: _____ First Name _____ Test: ___ Antibody ___ Antigen

Test Date: _____

Test recommended for: _____ Symptomatic Screening _____ Close Contact _____ Asymptomatic Screening

Notes: _____

COVID-19 Screening Informed Consent and Waiver

This consent provides West Central C.U.S.D. #235 your permission to perform a COVID-19 screening procedure based on West Central C.U.S.D. #235's need to maintain a safe environment for students, employees, contractors, vendors, and other essential persons, including visitors and guests, with whom you may come into contact. By signing below, you are indicating that you voluntarily consent to this procedure for the detection of COVID-19 for yourself or for the minor listed for which you have legal guardianship.

The tests used by West Central C.U.S.D. #235 have been allowed for use by the Food and Drug Administration ("FDA") but have not been approved by the FDA. A rapid test alone may not be sufficient to detect or rule out the possibility that you have been exposed to or are infected with COVID-19. You should carefully monitor your own symptoms, and notwithstanding the results of any testing, you must stay home and should consult with your physician if you experience symptoms of COVID-19.

Privacy Notice

We are collecting your test sample and other information to determine the presence of the COVID-19 virus and antibody tests to determine possible past exposure to the virus and to provide you with information on your results. You are not legally required to provide this data, but if you do not provide this information, we cannot test you. Access to your private information, such as your name and medical information, will be limited to the District medical staff conducting the test, District administrative staff, local and state public health staff, or their contractors to conduct disease investigations or other public health activities, or other persons or entities authorized by law.

You also understand that **your records** are protected under state and federal privacy laws and cannot be disclosed without your written consent, unless otherwise provided by law. By providing your consent to be tested, you authorize your information and test results to be shared as described in the above Privacy Notice.

Disclosure to Government Authorities: I acknowledge and agree that West Central C.U.S.D. #235 may disclose my test results and associated information to appropriate county, state, or other governmental and regulatory entities as may be permitted by law.

Authorization and Consent for COVID-19 Testing:
I voluntarily consent and authorize West Central C.U.S.D. #235 "District" to conduct collection, testing, and analysis for the purposes of a COVID-19 screening test. I acknowledge and understand that my COVID-19 test will require the collection of an appropriate sample by a trained member of the staff through a nasopharyngeal swab, oral swab, or other recommended collection procedures (rapid antigen test), or a whole blood sample through a finger-stick procedure (rapid antibody test). I understand that there are risks and benefits associated with undergoing a test for COVID-19 including the possibility of slight discomfort and/or an incorrect result (false positive or false negative test results). I understand that I have the right to discuss the proposed testing with my physician, to learn about the purpose, potential risks and benefits of any testing. 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.

Release:
As consideration for the testing, and to the fullest extent permitted by law, I hereby, for myself, and for my heirs, executors, administrators and assigns, waive, release and forever discharge the District, its Board members individually, administrators, officers, employees, volunteers, COVID-19 testing partners, and agents from any and all manner of action and actions, cause and causes of action, suits, debts, accounts, damages, claims and demands whatsoever in law, or in equity, which I may now have or may acquire, by reason of personal injury or death or loss of or damage to personal property or any other reasons, which may be related in any way to the COVID-19 testing provided by the District or in connection with any act or omission relating to my COVID-19 test or the disclosure of my COVID-19 test results.

Indemnification:
I hereby agree to indemnify, defend, and hold harmless the District, its Board members individually, administrators, officers, employees, volunteers, COVID-19 testing partners, and agents from any and all claims of responsibility or liability for personal injury, property damage, or loss which may arise from or is in any way connected with the COVID-19 testing provided by the District.

Acknowledgement:
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 test being used, procedures to be performed, potential risks and benefits, and any associated costs. I have been provided an opportunity to ask questions before proceeding with a COVID-19 test, and I understand that if I do not wish to continue with the collection, testing, or analysis of a COVID-19 test, I may decline to receive continued services. I have read the contents of this form in its entirety and voluntarily consent to undergo testing for COVID-19.

Informed Consent and Waiver completed by:

PRINTED STUDENT NAME: _____

PRINTED PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

RELATIONSHIP TO STUDENT (if applicable): _____

CONTACT PHONE NUMBER: _____ **Date (mm/dd/yyyy):** _____