Central Dauphin School District

COVID-19 Consent Form

As the parent or guardian of the minor student named below or as an eligible student, I authorize Central Dauphin School personnel to collect a nasal swab from said student for the presence of SARS-CoV-2. I understand that Polymerase chain reaction (PCR) testing will be performed from this swab by Quest Diagnostics.

I understand and agree that my child/myself may be tested as often as determined necessary by an authorized medical provider. This consent extends to all PCR testing performed during the 2020-2021 school year unless revoked in writing.

Furthermore, I understand the potential risks of this procedure may include but not be limited to:

- Possible discomfort of other complications that can occur during sample collection.
- Possible false negative or inconclusive results.

I understand that the potential benefits may include but not be limited to:

- The result, along with other information, may help me to make informed decisions about my care.
- The results of this test may help limit the spread of COVID-19 to my family and others in my community and the school community.

By signing this consent, I authorize Quest Diagnostics to release the results of my test to the District or the District's authorized health care providers and I authorize the District to release the results of my test to myself, the District, the health care provider that ordered my test, and to the Pennsylvania Department of Health and certain federal, state or local government agencies as required by law.

I understand that I will be notified of the results when available. I acknowledge that I/my child and any household contacts should quarantine until test results are available. I understand that the results will also be available on the Quest My Chart portal if I choose to enroll.

I understand that the school physician and nurse will be notified of results and will implement contact tracing if there is a positive test result. I acknowledge that a positive test result is an indication that I/my child must self-isolate and wear a mask or face covering as directed.

I understand that the District's testing unit is not acting as my/my child's medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action when I receive my/my child's test results. I understand that it is recommended that I contact my/my child's primary care provider for evaluation and treatment recommendations.

By signing below, I acknowledge that I have read the information above, that I understand the test purpose, procedures, possible benefits and risks, and that I fully understand and agree to testing. 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. If I wish to revoke this authorization, I will do so in writing by contacting the school nurse. I voluntarily agree to PCR testing for myself/my child.

_____ _____

Student Name Student Date of Birth

_____ _____

Parent/Guardian Name Today's Date

_____

Parent/Guardian Signature or Eligible Student Signature