QuickVue SARS CoV-2 Antigen and/or Accula SARS CoV-2 PCR Test for
Symptomatic and Asymptomatic Individuals- Grade 5-12

By completing and submitting this form, I confirm that I am the appropriate parent / guardian to provide consent for COVID-19 test to be done on my child. I understand that testing will be done by school nursing staff using the nasal swab method.
Symptomatic students will be administered the QuickVue SARS CoV-2 antigen test and / or Accula SARS CoV-2 PCR test (nasal swab). Symptoms consistent with COVID-19 can include new cough, difficulty breathing, loss of taste or smell, fever, chills, congestion/runny nose, sore throat, headache, nausea/vomiting, diarrhea, muscle pain, fatigue, or isolated symptoms (e.g., isolated runny nose, isolated headache, or isolated abdominal pain without fever).

Testing of asymptomatic individuals (individuals who are not sick):

- Can be done for those who request it for early return from quarantine. These tests can be done on day 6, 7 or 8 after the last contact with a positive case so that a student can return on day 8 if negative test and no symptoms. This must be scheduled with the nurse.
- Can be done if a test is required for school related travel or athletics. This must be scheduled with the nurse.

I understand that authorizing a Covid-19 test for my student is optional and that I can refuse to give this authorization, in which case, my student will not be tested. I further understand that my student **must** stay home if feeling unwell.

I understand that a Positive test do not rule out bacterial infections or co-infection with other viruses and that my child should see their health care provider for further guidance.

Negative results do not preclude SARS-CoV-2 (Covid-19) infection and should not be used as the sole basis for clinical management decisions.

Student Demographic Information:
Student's First Name: _________________ Middle Name: _________________Last Name: ______________
What is the student's date of birth? _______________

Parent/Guardian Information:
Parent/Guardian First Name: _____________________________ Last Name _________________________
Parent/Guardian Phone Number: _____________________________ email __________________________
Parent will be contacted prior to any testing to discuss rational for test recommendation (even if consent for testing has been previously signed).

Consent for testing: Must initial and sign for consent, check any/all that apply
_____ In the event my student shows symptoms of COVID-19, I authorize school nursing personnel to administer the QuickVue antigen test and/or Accula PCR test on my student.
_____ I authorize testing for early return from quarantine (must schedule with school nurse)
_____ I authorize testing for school related trips and athletics (must schedule with school nurse)

Your signature below indicates that you understand that my student's test results will be shared with the Tennessee Department of Health and that you have received the privacy notice.

Parent/legal Guardian Name (Print) ____
Parent/Legal guardian Signature: ______________________________________, Date: ______________

Consent is valid for 1 year unless revoked.