Smithfield Public Schools
STUDENT CONSENT FORM FOR OPTIONAL COVID-19 TEST-to-STAY PROGRAM

TO BE COMPLETED BY PARENT / GUARDIAN

- You will be notified of individual test results either via **phone or email.**
- If your child has tested positive for COVID-19 in the past 90 days, they should not participate in COVID-19 testing to avoid false positives.
- Unvaccinated individuals are strongly encouraged to participate in school-based asymptomatic testing and are eligible to participate in Test-to-Stay.
- Vaccinated individuals may participate in school-based asymptomatic testing.

Parent/Guardian Print Name:	
Parent/Guardian Cell/Mobile #:	
Parent/Guardian Email Address:	

Child/Student Information

Child/Student Print Name:	
School Name:	
Grade Level:	
Date of Birth: (MM/DD/YYYY)	
Race (pick one):	☐ American Indian ☐ Alaskan Native Asian Black ☐ African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Prefer not to say
Ethnicity (pick one):	☐ Hispanic or Latinx ☐ Not Hispanic or Latinx ☐ Prefer not to say
Gender:	(if more than one option applies, please select Other) ☐ Male ☐ Female ☐ Transgender ☐ Nonbinary ☐ Other ☐Unknown ☐ Prefer not to say
Consent/ Opt Out:	☐ Yes, I provide consent for my student to participate in the COVID-19 Test-to-Stay Program (please read page 2 and sign the form) ☐ No, I do not provide consent for my student to participate in COVID-19 testing. (No further action needed)

PLEASE COMPLETE OTHER SIDE

By completing and submitting this form, I confirm that I am the appropriate parent, guardian, or legally authorized individual to provide consent and:

- I authorize my child to participate in the Smithfield Public School's Test-to-Stay program whereby the school may periodically administer COVID-19 tests to my child as provided herein.
- I authorize collection and testing of a sample from my child for COVID-19 at school for an individual test (antigen). By signing this form, I am consenting to antigen testing. I understand that Smithfield Public Schools will inform me of the services the school is administering prior to the start of, or any change to, the school's COVID-19 testing program.
- Individual testing on close contacts (Test-to- Stay): for asymptomatic close contacts to be tested daily for **at least five (5) days** from the first day of exposure, with individuals testing negative being allowed to remain at school.
- I understand that all sample types will be non-invasive, short nasal samples.
- I understand that I will be notified about the results of any individual test for COVID-19 performed on my child.
- I understand that there is the potential for a false positive or false negative COVID-19 test result, no matter the kind of testing being performed. Given the potential for a false negative, I understand that my child should continue to follow all COVID-19 safety guidance and follow school protocols for isolating and testing in the event my child develops symptoms of COVID-19.
- I understand that staff administering all COVID-19 testing have received training on safe and proper test administration. I agree that neither the test administrator nor the Smithfield Public Schools nor any of its trustees, officers, employees, or organization sponsors are liable for any accident or injuries that may occur from participation in the COVID-19 Test-to-Stay Program.
- I understand that my child must stay home if feeling unwell. I acknowledge that a positive individual test result is an indication that my child must stay home from school, self-isolate, and continue wearing a mask or face covering as directed in an effort to avoid infecting others.
- 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. I understand I am financially responsible for any care my child receives from their healthcare provider.
- I understand that COVID-19 testing may create protected health information (PHI) and other personally identifiable information relating to my child, and such information will only be accessed, used, and disclosed in accordance with HIPAA and applicable law. Pursuant to 45 CFR 164.524(c)(3), I authorize and direct the testing provider to transmit such PHI to my child's school, the Rhode Island Department of Health and the testing laboratory.
- I understand that participation in the COVID-19 Test-to-Stay Program may require the school to disclose my child's identity, demographic, and contact information from education records to the testing provider and may require the school to disclose my child's identity, demographic, and contact information from education records to the Rhode Island Department of Health. Pursuant to FERPA, 34 CFR 99.30, I authorize my school to disclose such personally identifiable information (PII) as is required for my child to participate in COVID-19 testing.
- I understand that authorizing these COVID-19 tests for my child is optional and that I can refuse to give this authorization, in which case, my child will not be tested.
- I understand that I can change my mind and cancel this permission at any time, but that such cancellation is forward-looking only, and will not affect information previously released. To cancel this permission for COVID-19 testing, I need to contact the Smithfield Public Schools Covid Response Team at mmoroni@smithfield-ps.org
- I authorize the testing provider and/or the Rhode Island Department of Health to monitor aspects of the COVID-19 virus, such as tracking viral mutations, by analyzing positive sample(s) for epidemiological and public health purposes. Results of such analyses will not be personally identifiable nor create personally identifiable information.

I, the undersigned, have been informed about the COVID-19 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 for my child.

Signature of Parent/Guardian: **Date:**