USD 223 Consent to COVID-19, Influenza A/Band Streptococcus test

Please carefully read and provide written acknowledgment of the following consent:

a. I authorize a testing administrator associated with the school district to conduct collection and testing for COVID-191 Influenza A/8, Streptococcus (strep throat) through a saliva sample, nasal or nasopharyngeal swab collection by the school Registered Nurse.

b. I authorize my test result, or the test result of my child if my child is under the age of 18 years, to be disclosed to the county, state or to any other governmental entity as may be required by law.

c. I understand that as well as with any medical test there is the potential for a false positive or false negative COVID-19 test result.

d. I give permission for my school district or the Washington County Health Department to contact me using non-secure methods (text or e-mail) regarding the test results, and I understand the risk involved.

_____	_____
Student Name	Grade
_____	_____
Student Name	Grade
_____	_____
Student Name	Grade
_____	_____
Student Name	Grade
_____	_____
Student Name	Grade
_____	_____
Parent Signature	Date