COVID-19 Release of Information and Informed Consent for Testing

Staff Name:	
Date of Birth:	**Contact Number:**
Address:	
City& State:	**Zip code:**

PLEASE CAREFULLY READ, INITIAL AND SIGN THE FOLLOWING INFORMED CONSENT:

This consent form authorizes you to be tested for SARS-CoV-2, the virus that causes the novel coronavirus COVID-19.

Why would I need to be tested?

You are displaying symptoms known of COVID-19.

How is the test conducted?

Samples for testing will be collected by using a nose swab (small swab put into the nose).

By signing this form, I agree to the following: (Please initial next to each statement and sign the bottom)

____a. I authorize Lake Wales Charter Schools Health Services to conduct collection and testing for COVID-19 through a nasal swab, as directed by an authorized medical professional or public health official. This consent extends to all COVID-19 testing performed during the 2020- 2021 academic year.

____b. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.

____c. I acknowledge that a positive test result is an indication that I must self-isolate and will be excluded from in person learning until the isolation period is complete per CDC guidelines.

____d. I understand that Lake Wales Charter Schools Health Services is not acting as my 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 test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.

____e. I understand that, as with any medical test, there is the potential for a false negative COVID-19 test result. If I am symptomatic, I will be required to have a negative PCR COVID-19 result or an alternate diagnosis in written form from my physician before I will be allowed back to school/work.

____f. I understand that there will be no out-of-pocket cost for this testing.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks. 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.

Check one and sign below.

____I voluntarily consent to COVID-19 testing for myself.

_____I DO NOT consent to COVID-19 testing for myself.

_____ _____ _____

Printed Name Signature Date