SAUSALITO MARIN CITY SCHOOL DISTRICT

INFORMED CONSENT FOR COVID-19 TESTING

Individual Tested Name-Last	First	Middle
Date of Birth (mm/dd/yyyy)	Grade	Home Phone
Name of School	Parent/Legal Guardian Emergency Phone Number	

Please carefully read the following informed consent:

1. I, on behalf of myself or my minor son/daughter/legal dependent (the “student”), authorize SAUSALITO MARIN CTY School District (hereinafter "SMCSD”) and/or an independent laboratory acting on SMCSD’s behalf to conduct collection and testing for exposure to the Novel Corona Virus (COVID-19) through a mid-turbinate nasal swab, saliva sample, or other minimally or non-invasive sample collection method as ordered by an authorized medical provider.
2. I acknowledge that minimally invasive sample collection methods, such as collection through a mid-turbinate nasal swab, can result in varying levels of discomfort during sample collection.
3. I understand that SMCSD’s independent laboratory partners are operating, as permitted under applicable laws and regulations, at various stages of the U.S. Food and Drug Administration’s Emergency Use Authorization submission, acknowledgment, and approval process.
4. I acknowledge that, if the student receives a positive test result, I must ensure that the student abides by all applicable federal, state and/or local requirements with respect to isolation and quarantine to avoid infecting others.
5. I further acknowledge that, in the event of a positive test, SMCSD and/or individuals or contractors acting on its behalf, may contact me and those who may have been exposed to the student and the student’s identity may be disclosed to certain individuals to the extent necessary to protect the health and safety of those exposed.
6. I understand that by signing this document and agreeing that the student shall undergo COVID-19 testing, that I am not creating a patient relationship with SMCSD. I understand that SMCSD is not acting as a medical provider for the student. Testing does not replace treatment by a medical provider. I assume complete and full responsibility to take appropriate action with regards to the test results for the student. I agree I will seek medical advice, care and treatment from a medical provider for the student to the extent such medical advice, care and treatment becomes necessary.
7. I understand that, as with any medical test, there is the potential for false positive or false negative test results to occur.
8. I understand that SMCSD has engaged certain third-party contractors and consultants to assist it in administering its COVID-19 testing program. I further understand that in order for the COVID-19 testing program to be successfully administered, certain personal information regarding the student will need to be communicated to

such contractors and consultants for purposes of administering the program, and only to the extent necessary to the administration of the COVID-19 testing program. This includes certain information contained within SMCSD's Student Information System (SiS), and may include personally identifiable information protected under the Family Educational Rights and Privacy Act, including student name, school, grade level, and cohort. I hereby expressly authorize such information regarding the student to be disclosed as described herein to the extent necessary to the administration of the COVID-19 testing program.

9. I understand that neither I nor my family will be charged directly for services. Third-party payment sources may be billed.
10. By signing this form, I acknowledge that I have received a copy of SMCSD's Notice of Privacy Practices.

Medical records will be kept in a confidential manner; however, I acknowledge that SMCSD may release information regarding treatment to third party payors such as Medi-Cal or insurance companies for the purpose of billing. I also understand that public information such as immunization history and/or communicable disease may be shared with the school nurse to protect the health of other students. I understand information may also be disclosed to certified third parties to facilitate the transmission of electronic health records.

ACCEPTANCE

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 consent, and I have been told that I can ask other questions at any time. I, on behalf of the student, voluntarily agree to testing for COVID-19.

Signature	Relationship to student	Date (mm/dd/yyyy)
Address	Telephone	
Signature verified by (**OFFICE USE ONLY**)	Date (mm/dd/yyyy)	

Ed. 040121