DIMMICK COMMUNITY CONSOLIDATED SCHOOL DISTRICT #175
"EXPECT EXCELLENCE in CHARACTER, ACHIEVEMENT and LEADERSHIP"
297 North 33rd Road, LaSalle, IL 61301
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STUDENT/PARENT or EMPLOYEE CONSENT FORM

Rapid Result Antigen Test for COVID-19 Infection

Please list all members of a single family:

Student Name _____ **Birthdate** _____
Student Name _____ **Birthdate** _____
Student Name _____ **Birthdate** _____
Student Name _____ **Birthdate** _____

Family Address _____ **City** _____ **Zip** _____

I, _____ (**Parent/Guardian or Employee Name Printed**) have read and signed the attached information, terms, and conditions regarding parent/guardian and or employee consent to COVID-19 diagnostic testing of my child(ren) listed above.

I understand that all testing is offered on a voluntary basis. In addition to this written consent on file, individual consent will be obtained from the student and parent or employee. Notification will be verified before each test is performed.

Each positive and negative result will be sent to the IDPH reporting system within 24 hours of test administration, to the LHD, to the office of the physician on file if requested by the parent, as well as to the parent of the student (and/or student as age appropriate) if applicable.

Parents will be notified of the result by phone. Please indicate the phone number to best report the results. Employees will receive verbal notification. **Phone Number** _____

Please indicate if a voicemail with the results may be left at this number. _____ **YES** _____ **NO**

In compliance with the FDA Emergency Use Authorization, this rapid antigen test will be offered to symptomatic students and staff as well as to those individuals who are unvaccinated and require a weekly COVID-19 test as per Executive Order.

Symptomatic individuals who test negative and who are not considered close contacts to a confirmed case of COVID-19 may be required to have a second antigen test within 48 hours of a negative result if symptoms persist in order to remain at school.

For anyone who has a negative rapid antigen test result, is symptomatic and has a known exposure to a confirmed case of COVID-19, will be required to get a follow-up with an RT-PCR test within 2 days to confirm the negative result before returning to school.

I give consent for the Dimmick staff trained in accordance with CDC, IDPH, and LHD guidelines to administer the Abbott BinaxNow rapid result antigen test to the above-named individual(s).

_____ _____
Signature of Parent/Guardian or Employee **Date Signed**

Complete Reverse Side > > > > > > >

Information Regarding Consent for COVID-19 Diagnostic Testing

Consent to COVID-19 diagnostic testing includes the collection, testing, and analysis of a sample specimen by Dimmick CCSD #175 (the "District") or an appropriate representative(s) of the District. I acknowledge and understand that this testing of my child will require the collection of a sample specimen which may be obtained by nasal or oral swab, or saliva collection procedures from trained district personnel. I understand that there are risks – including, but not limited to the potential for false positive or false negative test results – and benefits – including, but not limited to helping to maintain a safe school environment – associated with my child undergoing a diagnostic test for COVID-19. I assume full responsibility for taking appropriate action with regards to my child's test results. Should I have questions or concerns regarding my child's results, confirmation of the test results, or a worsening of my child's condition, I shall promptly seek advice and treatment from an appropriate healthcare provider. _____ **Parent/Guardian or Employee Initial**

Terms and Conditions

a. Notice of Student Privacy Rights and Practices: All results obtained through the District's testing protocol shall be used for COVID-19 mitigation, tracking, and other purposes which may include surveys and data collection by the Illinois State board of Education. All such results shall be retained in a confidential manner consistent with applicable State and Federal law and regulation.

b. Attestation: I attest that I have authority to execute this form providing consent for my child to participate in this COVID-19 diagnostic testing protocol.

c. Voluntary Participation: I understand that my child's participation in this COVID-19 diagnostic testing protocol is voluntary. I understand that my child may continue to attend school if I do not consent to their participation in this testing protocol or withdraw my consent, except for any required school exclusion due to an isolation/quarantine period consistent with local public health department, IDPH or CDC guidance.

d. Disclosure of Test Results and Associated Information: I acknowledge that the District may disclose my/my child's COVID-19 test results and my/my child's associated information to appropriate representatives of the District and/or appropriate Federal, State, county, or other governmental and regulatory entities as may be permitted by law. Due to the ongoing public health crisis, this may include sharing my/my child's test results and associate information with public health authorities. I understand that the District will also provide me with information on my child's test results. I understand that the District will notify me of my child's test results via phone.

e. Release: As consideration for this testing, I hereby, for myself and for my heirs, executors, administrators and assigns, waive, release and forever discharge the District, its Board members individually, administrators, officers, employees, volunteers, agents and representatives from any and all manner of action and actions, cause and causes of action, suits, debts, accounts, damages, claims and demands whatsoever in law, or in equity, which I may now have or may acquire, by reason of personal injury or death or loss of or damage to personal property or any other reasons, which may be related in any way to the COVID-19 testing provided by the District which may accrue on account of my child's participation. I acknowledge and agree that I have read, understand, and agreed to the statements contained within this form. I have been informed about the purpose of the COVID-19 test being used, the procedures to be performed, the potential risks and benefits, and any associated costs. I have been provided an opportunity to ask questions before providing my consent to COVID-19 testing and I understand that I may withdraw my consent to COVID-19 testing at any time. I have read the contents of this form in its entirely and I voluntarily consent to testing for COVID-19.

f. Indemnification: I hereby agree to indemnify, defend, and hold harmless the District, its Board members individually, administrators, officers, employees, volunteers, and agents from any and all claims of responsibility or liability for personal injury, property damage, or loss which may arise from or is in any way connected with the COVID-19 testing provided by the District on account of mu child's participation.

g. Effect of Consent: By signing below, I am indicating that I voluntarily consent to and authorize the diagnostic testing described above for the detection of COVID-19. This consent is ongoing for the duration of the District's implementation of a diagnostic testing protocol, and I acknowledge that it may be revoked at any time in writing.

The tests used by the District have been approved for diagnostic use through Emergency Use Authorization by the Food and Drug Administration ("FDA"). However, a rapid test alone may not be sufficient to detect or rule out the possibility that an individual has been exposed to or is infected with COVID-19. Individuals who receive a test should carefully monitor their own symptoms

_____ _____

Signature of Parent/Guardian or Employee **Date Signed**