HCPS COVID Testing Consent Form

Informed Consent for Coronavirus (COVID-19) Screening

I, Parent/Legal Guardian of [Insert Student/Staff Member Name]_____ authorize Wild Health and/or trained HCPS personnel to conduct collection, testing, and screening for COVID-19 through an anterior nasal swab. I acknowledge that this screening is being conducted in the Henry County School District at my request and any results or findings are for its benefit in order to determine whether it is safe for [Insert Student/Staff Name] _____ to attend school. I further acknowledge and expressly consent to each of the following:

(1) I authorize my child's test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.

(2) I acknowledge that a positive test result is an indication that my child must self-isolate in an effort to avoid infecting others.

(3) I understand that my child is not creating a patient relationship with Wild Health by participating in this screening. I further understand that Wild Health is not acting as my child's medical provider and is not conducting a diagnostic test.

(4) I understand that testing does not replace treatment by my child's medical provider. I assume complete and full responsibility to take appropriate action with regards to my child's test results. I agree that I will seek medical advice, diagnosis, care, and any necessary treatment from a medical provider for my child if I have questions or concerns, or if my child's condition requires me to do so. If my child does not have a medical provider, I may ask Wild Health and/or HCPS Health Services Department personnel for a list of health care professionals from whom my child may receive follow-up care.

(5) I understand that, as with any medical test, there is the potential for the occurrence of a false positive or false negative test result.

I have been given the opportunity to ask questions about this consent before I sign, and I have been told that I can ask other questions at any time.

I agree to the following testing options for my student/myself (**please check all that apply**):

◯ Districtwide Bi-Weekly Surveillance Testing: Routine testing twice a month

◯ Test-to-Stay Strategic Testing: Test upon **SCHOOL** exposure (every 48 hours during what would have been quarantine period; if negative and no symptoms, student/staff can stay at school during this time)

◯ Symptomatic Testing: Test if a student or staff presents with symptoms

Student or Staff Member Name: _____

School: _____

Parent/Guardian Name (please print): _____

Staff Member OR Parent/Guardian Signature: _____

Check if applicable: ( ) Parent ( ) Guardian ( ) Legally Authorized

Date Signed: _____

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