COVID-19 Testing Consent Form

To be completed by student parent or guardian			
Parent/Guardian Information			
You will be notified with test results in writing.			
Parent/Guardian Print name:			
Parent/Guardian Mobile number:			
Parent/Guardian Email address:			
Student information			
Student name:			
Home address:		City:	
ZIP code:		County:	
Date of birth: *(MMIDDIYYYY*		Grade level:	
Student name:			
Home address:		City:	
ZIP code:		County:	
Date of birth: *(MMIDD/YYYY*		Grade level:	
Student name:			
Home address:		City:	
ZIP code:		County:	
Date of birth: *(MM/DD/YYYY*		Grade level:	

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Consent

By completing this form and returning it to my school, I confirm that I am the parent or guardian of the student(s) listed above, and that I consent to allow for my student to be tested for COVID-19 during the 2021-2022 academic school year by providing either a shallow nasal swab or a saliva sample. COVID-19 testing may be offered to students in three circumstances: (1) if my student(s) develop(s) new symptoms of COVID-19 while at school; (2) if my student(s) is exposed to COVID-19 in a school group and the local public health department recommends testing; (3) once a week screening testing for COVID-19. I understand that I may consent to any or all types of testing.

I understand that COVID-19 testing for the student(s) is optional and that I may refuse to give consent, in which case, my student(s) will not be tested. I understand that my student(s) must stay home from school if feeling unwell.

I understand that an independent laboratory acting on behalf of my school will conduct the weekly screening testing. I understand that in order for weekly screening testing to be performed at an independent laboratory, certain personal information regarding my student(s) will need to be communicated to the laboratory for purposes of administering the program, and only to the extent necessary to administer the program, including student name, date of birth, and school cohort.

I understand that the school is not acting as my student's healthcare provider, this testing does not replace treatment by my student's healthcare provider, and I assume complete and full responsibility to take appropriate action regarding the student's test results. I understand that it remains my responsibility to seek medical advice, care and treatment for my student(s) from their healthcare provider.

I understand that there is a possibility of false negative COVID-19 test results and that my student(s) could still be infected with COVID-19 even if the test result is negative. I also understand that if my student(s) tests positive for COVID-19, the test result will be reported to the local public health authority as required by law.

Personal health information will not be released without written consent except when required by law.

- ☐ I give permission for school staff to test this student(s) for COVID-19 if new symptoms develop at school.
- ☐ I give permission for school staff to test this student(s) if they are exposed to COVID-19 within their school cohort and testing is recommended by the local public health authority.
- ☐ I give permission for my student(s) to participate in weekly screening testing for COVID-19.

Signature of Parent/Guardian Date

You can get this document in other languages , large print, braille, or a format you prefer. Contact the Coronavirus Response and Recovery Unit (CRRU) at 503-979-3377 or email CRRU@dhsoha.state.or.us . We accept all relay calls or you can dial 711.