Village Green Virtual STAFF CONSENT FORM FOR ABBOTT BINAXNOW TESTING

TO BE COMPLETED BY STAFF OR STUDENTS CONSENTING FOR THEMSELVES

Personal Information

You will be notified of individual follow-up test results either via phone or email.

Full Name:	
Cell/Mobile #: *Note: results will be texted to this cell #*	
Email Address:	
Date of Birth	
Have you been diagnosed with COVID-19 in the past 90 days?	**Yes**, I have tested positive for COVID-19 in the past 90 days (note: individuals who have tested positive for COVID-19 in the past 90 days should not participate in pooled testing). ☐ **No**, I have **not** tested positive for COVID-19 in the past 90 days.

Student Information (If Applicable)

Grade Level: Classroom:

CONSENT

By completing and submitting this form, I confirm that I am the appropriate individual to provide consent and:

A. I authorize the collection and testing of any necessary individual diagnostic tests, including BinaxNOW rapid antigen tests and PCR/molecular tests.
B. I understand that all sample types will be non-invasive, short nasal swabs or saliva samples.
C. I understand that I will be notified about the results of any individual diagnostic test for COVID-19, including any BinaxNOW COVID-19 antigen test, performed on me.
D. I understand that there is the potential for a false positive or false negative COVID-19 test result from individual tests. Given the potential for a false negative, I understand that I should continue to follow all COVID-19 safety guidance, including mask-wearing and social distancing, and follow school protocols for isolating and testing in the event I develop symptoms of COVID-19.
E. I understand that staff administering BinaxNOW testing have received training on safe and proper test administration. I agree that neither the test administrator nor the **Village Green Virtual Charter School** nor any of its trustees, officers, employees, or organization sponsors are liable for any accident or injuries that may occur from participation in the COVID-19 testing program.
F. I understand that I **must** stay home if feeling unwell. I acknowledge that a positive **individual** test result is an indication that I must stay home from school, self-isolate, and continue wearing a mask or face covering as directed in an effort to avoid infecting others.
G. I understand the school system 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 with regards to 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. I understand I am financially responsible for any care I receive from my healthcare provider.
J. I understand that follow-up and BinaxNOW testing may create protected health information (PHI) and other personally identifiable information about me. Pursuant to 45 CFR 164.524(c)(3), I authorize and direct the testing provider to transmit such PHI to my school, the Department of Public Health, and the testing laboratory. I further understand that PHI may be disclosed to the Executive Office of Health and Human Services and any other party, as authorized under HIPAA.

K. **<u>For Students Only</u>**: I understand that participation in COVID-19 testing may require my school to disclose my identity, demographic, and contact information from education records to the testing provider and, for follow-up tests, will require the school to disclose my identity, demographic, and contact information from education records to the Department of Public Health. Pursuant to FERPA, 34 CFR 99.30, I authorize my school to disclose such personally identifiable information (PII) as is required for my participation in BinaxNOW testing.

L. I understand that authorizing these COVID-19 tests is optional and that I can refuse to give this authorization, in which case, I will not be tested.

M. I understand that I can change my mind and cancel this permission at any time, but that such cancellation is forward-looking only, and will not affect information I already permitted to be released. To cancel this permission for COVID-19 testing, I need to contact **Rochelle Baker, (401) 831-2878 ext. 114 or rbaker@vgcs.org.**

N. I authorize the testing provider to monitor aspects of the COVID-19 virus, such as tracking viral mutations, by sequencing viruses and other microbes present in the sample(s) for epidemiological and public health purposes. Results of such analyses will not be personally identifiable nor create personally identifiable information.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits, and risks, and I have received a copy of this Informed Consent. 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. I voluntarily agree to this testing for COVID-19.

Signature:		**Date:**