



Orientation Forms



Demographic Form

Complete **ONLY** items you wish to have corrected



Media Consent Form



Parent Portal Authorization Form



Updated Immunization Records

Copy of both sides of Immunization Card
OR Current Immunization Exemption Letter



THE VIRGIN ISLANDS DEPARTMENT OF
EDUCATION

Student Media Consent and Release Form

Throughout the school year, students may be highlighted in efforts to promote VI Department of Education activities and achievements. For example, students may be featured in materials to train teachers and/or increase public awareness of our schools through newspapers, radio, TV, the web, DVDs, displays, brochures, and other types of media.

I, as the parent or guardian of student _____, attending **Ivanna Eudora Kean High School**, hereby give the VI Department of Education (VIDE) and its employees, representatives, and authorized media organizations permission to print, photograph, and record my child for use in audio, video, film, or any other electronic, digital and printed media.

- a) This is with the understanding that neither VIDE nor its representatives, will reproduce said photograph, interview, or likeness for any commercial value or receive monetary gain for use of any reproduction/broadcast of said photograph or likeness. I am also fully aware that I will not receive monetary compensation for my child's participation.
- b) I further release and relieve VIDE, its Board, employees, and other representatives from any liabilities, known or unknown, arising out of the use of this material. I certify that I have read the Media Consent and Release Liability statement and fully understand its terms and conditions.

If parent/guardian chooses to change above authorization, he/she needs to do so in person at the child's school.

Please Print

Name of child _____ Grade _____

School **Ivanna Eudora Kean High School**

Home Address _____

City, State, Zip _____

Print name of parent/guardian _____

Phone Number _____

I **DO** give permission for my child to be photographed, interviewed or used in promotional materials

I **DO NOT** give permission for my child to be photographed, interviewed or used in promotional materials.

Parent / Guardian's Signature

Date

COVID-19 Testing Consent Form

I acknowledge and understand that I will perform the following specimen collections on myself: (i) a nasal swab for SARS-CoV-2 PCR testing. SARS-CoV-2 is the virus that causes COVID-19. I acknowledge and understand that if I am consenting to nasal swab testing for SARS-CoV-2 PCR for a pediatric individual age 3-12 an adult will perform their nasal swab collection, if they are age 13-17 an adult will supervise their nasal swab self-collection; however, if they are below the age of three I acknowledge and understand that a health care provider will conduct their nasal swab collection. I further acknowledge, understand, agree, certify, and authorize the following:

1. I have requested testing of my, my ward, or my child's specimen for SARS-CoV-2.
2. The SARS-CoV-2 PCR test involves a swab slid into the nostril to obtain a sample. It may be uncomfortable, painful, or potentially cause mild abrasion or bleeding. No long-lasting side effects from testing are expected. There is minimal risk with collection of a specimen with a nasal swab, but the nature of the collection may cause slight discomfort.
3. I understand that CEI, or an affiliated reference laboratory will perform the laboratory analysis on my specimen if I order SARS-CoV-2 PCR testing. I authorize CEI or a reference laboratory to perform SARS-CoV-2 PCR testing on my specimen.
4. Processing of the specimen and results may take between 3 to 4 days.
5. My results will be reported to Clinical Enterprise, Inc. Clinical Enterprise will make my test results available to the Assure™ digital health platform. If my specimen is individually tested, my test results will be available to me through the Assure™ platform.
6. These procedures and the results are not a substitute for medical advice or treatment from my personal health care provider. I will consult with and obtain care from a health care provider if I have tested positive for COVID-19, am experiencing symptoms, or have any other questions or concerns.
7. I am not entering into a doctor-patient relationship with CEI, Affinity Empowering, Inc., or another reference laboratory. Any questions that I have, or coordination of required follow up with a health care professional, is my responsibility.
8. CEI and its affiliates have infectious disease reporting responsibilities under applicable governmental regulations and will report my testing information in accordance with applicable regulations.
9. CEI and its affiliates also have reporting responsibilities under applicable governmental agreements providing for this testing, and will report my testing information in accordance with applicable agreements.

By clicking below, I acknowledge that I have read, understand, agree, certify, and/or authorize the information above and further agree that I and my heirs, executors and assigns hereby release CEI, Affinity Empowering, and other reference laboratories, including their respective employees, agents, and contractors from any and all liability and claims. I authorize CEI, its reference laboratories, and their respective employees to use and/or disclosure the PHI as described above. I do hereby expressly

and voluntarily authorize this use and release of information and declare that the information provided on this form is true and correct.

Last Updated 07 September 2021

By signing "I Agree and Consent," I am accepting and agreeing to be bound by this agreement and I represent and warrant that I have the right, authority, and capacity to accept and agree to be bound by this Agreement on behalf of myself or for those of which I am the legal guardian.

Name of Minor: FirstName_____LastName_____

Birthdate_____

Name of Parent/Guardian: FirstName_____ LastName_____

Cell phone number and email address for receiving COVID-19 test results

Cell Phone _____ Email_____

Parent/Guardian Signature_____ Date_____



Office of the Insular Superintendent

St. Thomas-St. John District
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Tel: 340-775-2250

Fax: 340-775-7381

Parent Portal Acceptable Use Policy Signature Page

Student's Last Name

(Please print clearly)

Student's First Name

Grade Level

School: Ivanna Eudora Kean High School

The Virgin Islands Department of Education, St. Thomas-St. John School District provides parent(s) or guardian(s) access to student information through the Parent Portal. Access to the system is available through the Internet and accounts are created by using web access information furnished by the school. Users must protect their login information in order to maintain security and are required to adhere to the Parent Portal Acceptable Use Policy. This signature page must be completed and returned for each student.

I have read and I understand and agree to the terms of the Parent Portal Acceptable Use Policy. I understand that access to the Parent Portal is designed for the educational support of my child and is not an official record.

I hereby expressly release the Virgin Islands Department of Education, the St. Thomas-St. John School District, its administrators, staff, employees, and agents from any and all claims, liability, loss, damages, and causes of action of whatsoever character and description which may arise out of, relate to, or is any way connected directly or indirectly to the use or inability to use the Parent Portal including but not limited to damage to personal equipment when connected to the Parent Portal or PowerSchool System.

Parent/Guardian Name: _____

(Please print clearly)

Parent/Guardian Signature: _____ Date: _____

Telephone Numbers: _____ Email _____



For Office Use Only

Parent Identification Verified: _____ District Student Number: _____

Date: _____ Name of District Official: _____