COVID-19 Diagnostic Testing Permission and Release Form (Student)

Student First Name: Middle Name:	Student Last Name:
Parent/Guardian First Name:	Parent/Guardian Last Name:
Student Date of Birth (MM/DD/YYYY):	Student's School:

I, the undersigned parent/guardian (or Student, if 18 years of age or older) have carefully read the statements herein and, after having been informed of the purposes, risks and benefits of screening testing, **voluntarily** consent to the collecting, testing and analysis for purposes of a COVID-19 diagnostic test. Accordingly, I understand that:

1. COVID-19 diagnostic testing is being offered as an **optional** service available to all Winston-Salem/Forsyth County Board of Education (WS/FCS) students and employees. COVID-19 diagnostic testing will be conducted by a representative of the Forsyth County Department of Public Health (FCDPH) and/or an employee of WS/FCS. I have had an opportunity to have my questions answered by my child's medical provider or by the FCDPH. The diagnostic test will require the collection of an appropriate sample by the FCDPH through a nasopharyngeal swab, oral swab, or other recommended collection procedures. I understand that there are risks and benefits associated with undergoing a diagnostic test, and that there is the potential for a false positive or false negative test result.

2. The FCDPH is not acting as a physician and is not providing medical services. Furthermore, diagnostic testing does not replace medical treatment provided by a physician. I assume full and complete responsibility for taking all necessary and appropriate action with regard to the test results and any medical care needed. If I have any questions or concerns, of if any symptoms of COVID-19 are developed, I will consult with a medical provider. It is my responsibility to inform Student's medical provider of a positive COVID-19 test result, and I understand that a copy of the positive result will not be sent to Student's medical provider by the FCDPH.

3. Student's test results may be shared without further authorization from me with WS/FCS and with the FCDPH and/or any other governmental and regulatory entitles, as may be permitted by law. If Student tests positive for COVID-19, I agree to adhere to all required exclusion and/or quarantine protocols until Student meets all necessary criteria for returning to school in accordance with the North Carolina Strong Schools Public Health Toolkit, a copy of which may be found at the following link: https://covid19.ncdhhs.gov/media/164/open. We agree and request permission for the School to release and excuse the Student from any school classes or other school activities so that the Student can participate in this event.

4. By executing this release, I/we assume any and all risk of injury associated with the diagnostic testing. We agree to release, hold harmless and indemnify the Winston-Salem/Forsyth County Board of Education, its members, agents, representatives and employees, from and against any and all claims, suits or causes of action we may have or incur arising from or out of an injury the Student may suffer as a result of participating in diagnostic testing other than an injury caused by willful or gross negligence or intentional wrongdoing by the WS/FCS, its agents or employees.

EMERGENCY CONTACT INFORMATION	
Alternate person to contact in an emergency:	Name of family physician:
Home phone: Work phone:	Physician's telephone:
Name of medical/hospitalization insurance company	Policy Number:

☐ ***(For students under 18 years of age)*** I authorize FCDPH to conduct the COVID-19 diagnostic testing for my Student.

☐ ***(For students over 18 years of age)*** I authorize FCDPH to conduct the COVID-19 diagnostic testing.

Parent Signature:	Date:
Student Signature:	Date: