Austin ISD COVID Individual Testing

TO BE COMPLETED BY PARENT, GUARDIAN OR ADULT STUDENT					
Parent/Guardian Information					
You will be notified with test results either via cell phone or email, or both.					
Parent/Guardian Print Name:					
Parent/Guardian Cell/Mobile #: *Note: results will be texted to this cell #*					
Parent/Guardian Email Address:					
Child/Student Information					
Child/Student Print Name:					
School ID #:					
Driver's License #: *(if applicable)*					
Street Address:		**City:**		**State:**	
Zip Code:		**County:**			
School:			**Grade Level:**		
Date of Birth: *(MM/DD/YYYY)*			**Age:**		
Race/Ethnicity:	☐ Asian ☐ Hispanic ☐ Native American/Indigenous ☐ Black ☐ White ☐ Unknown		**Gender:**	☐ Male ☐ Female ☐ Other/Unknown	
Physician or Healthcare Provider			**Phone Number**		

By giving your permission, your minor ("Minor" or "Test Taker" or "Student") will be able to diagnostic tests administered by school staff or its designee.

- Like most COVID-19 tests, neither the pooled nor diagnostic tests used in this program are FDA-approved. (Note: The word "approved" means a very specific thing in the eyes of the FDA. As of early 2021, no COVID-19 tests have been approved by the FDA.)
- Individual diagnostic tests may be used as "follow-up tests" if a pooled test produces a positive result. They may also be used on their own. **Your school or organization will determine when and how diagnostic testing will be used.**
- Since diagnostic tests do provide individual results, each family will be notified of all results from every diagnostic test their minor performs.
- Diagnostic testing may create Protected Health Information (PHI). We protect this information and only share it when required (e.g. with public health authorities).
- Your consent can be changed at any time.
- Potential risks from collecting a sample include slight discomfort.

By completing and submitting this consent, I confirm that I am the appropriate parent, guardian, or legally authorized individual to provide consent for the Test Taker and:

A. I authorize the collection and testing of individual diagnostic tests as requested by Test Taker's organization or school on the Test Taker (including rapid antigen tests and PCR/molecular tests). I understand that all sample types will be non-invasive, short nasal swabs or saliva. Potential risks from sample collection include discomfort from the insertion of the swabs. The irritation is expected to be brief.
B. I understand that individual diagnostic tests are FDA authorized under an emergency use authorization.
C. I understand that, as with any COVID-19 test, there is the potential for a false positive or false negative COVID-19 test result.
D. I understand that neither the Test Taker's school or Organization or designee is acting as the Test Taker's medical provider, this testing does not replace treatment by the Test Taker's medical provider, and I assume complete and full responsibility to take appropriate action with regards to the Test Taker's test results. I will not make medical decisions without consulting a healthcare provider or disregard medical advice from my healthcare provider or delay seeking such advice based on the test results I receive from pooled or individual testing.
E. I understand that follow-up testing may create protected health information (PHI) and other personally identifiable information of the student. Pursuant to 45 CFR 164.524(c)(3), I authorize and direct test administrator to transmit such PHI information to the Test Taker's School or Organization, the applicable state departments of public health and department education, and the testing provider as appropriate. I further understand that with any additional submittal of a health questionnaire to request an individual COVID-19 test, I consent to health insurance information, testing, and results being shared with my health insurer or government agency paying for my testing for the purposes of payment, treatment, and/or healthcare operations, and as otherwise described in HIPAA & Privacy Policy. I understand that authorizing the above mentioned testing is optional and that I can refuse to give this authorization, in which case, the test taker will not be tested.
F. 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 the Test Taker's School or Organization.

I have read the above information about the Program, the description of the test samples to be collected, and possible risks of the program. I voluntarily agree to allow Test Taker as a minor to participate in individual testing as applicable **and understand that this consent is effective for the remainder of SY 2021-2022 unless I cancel permission.**

Parent/Guardian/Adult Student Printed Name:	
Parent/Guardian/Adult Student **Signature**:	
Date :	