



**Easton School District No. 28**  
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## COVID-19 Rapid Testing Consent Form for Students 2021-2022

### **Purpose:**

COVID-19 is an infectious disease that is spread primarily from person-to-person through respiratory droplets. Close proximity to others presents a risk of infection and disease spread. To prevent the spread of COVID-19, testing, contact tracing, and isolation of infected people supports the health and safety of the community.

### **Authorizations:**

- \_\_\_\_\_ I authorize the Easton School District COVID Testing team to administer COVID-19 rapid antigen tests to my student for the duration of testing done at school.
- \_\_\_\_\_ I authorize this testing team to conduct collection and testing for COVID-19 through a nasal swab to screen for COVID-19.
- \_\_\_\_\_ I understand my student's test results will go to the health departments in my county or state or to any other governmental entity the law requires.

### **Acknowledgments:**

**I voluntarily agree for my student to be tested for COVID-19.**

### **I assume complete and full responsibility to take appropriate action with regard to my student's test results.**

I acknowledge a positive test result is an indication my student must self-isolate and wear a mask or face covering as directed to avoid infecting others. I understand, as with any medical test, this COVID-19 test has the potential for false results (test is positive but my student does not have the infection or false negative, test is negative but my student has the infection). I agree to seek medical advice, care and treatment from my healthcare provider if I have questions or concerns, or if my student's condition worsens. I understand the testing team is not acting as a healthcare provider, and this testing does not replace treatment by a healthcare provider.

I understand the test purpose, procedures, possible benefits and risks, and I can request a copy of this consent form. I can ask questions before I sign this consent form, and I understand I can ask additional questions at any time.

I understand that if my student develops any symptoms of COVID-19, I must call and notify the school district to discuss my student's plan to return to school.

Student's Name: \_\_\_\_\_ Student's DOB: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_