



THORP SCHOOL DISTRICT NO. 400

Post Office Box 150 · 10831 N. Thorp Highway · Thorp, Washington 98946
Phone 509-964-2107 Fax 509-964-2313
www.thorpschools.org

COVID-19 Rapid Testing Consent Form for Students

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 Thorp School District COVID testing team to administer COVID-19 rapid antigen tests to my student for the duration of the testing opportunities.

_____ 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.

Acknowledgements:

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: _____ **Contact**

Information for Test Results:

Contact Name: _____

Relationship to Student: _____

Phone Number: _____

Email: _____

If results are not detected, which communication method do you prefer? Email Phone