HAVERHILL PUBLIC SCHOOLS
2022-2023
STAFF CONSENT FORM FOR SYMPTOMATIC COVID-19 TESTING

Staff Member Information

Print Name:					
Date of Birth: *(MM/DD/YYYY)*					
Address:		**City:**		**Zip Code:**	
Race (pick one):	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Prefer not to say				
Ethnicity (pick one):	☐ Hispanic or Latinx ☐ Not Hispanic or Latinx ☐ Prefer not to say	**Gender:**	☐ Male ☐ Transgender ☐ Female ☐ Prefer not to say		
Consent Opt In/Out:	☐ **Yes**, I provide consent to participate in symptomatic COVID-19 testing *(please read and sign form below)* ☐ **No**, I do not provide consent to participate in symptomatic COVID-19 testing. *(No further action needed)*				

CONSENT

By completing and submitting this form, I confirm that I provide consent to:

A. I authorize collection and testing of a sample for COVID-19 at school for an individual antigen test.
B. Individual testing on symptomatic individuals may be performed with consent when individuals present symptoms while at school, or in past 24-48 hours.
C. I understand that all sample types will be minimally-invasive, short nasal swabs.
D. I understand that I will be notified about the results of any individual test for COVID-19 performed.
E. I understand that there is the potential for a false positive or false negative COVID-19 test result, no matter the kind of testing being performed. Given the potential for a false negative, I understand that I should continue to follow all COVID-19 safety guidance, and follow school protocols for COVID-19.
F. I understand that staff administering all COVID-19 testing have received training on safe and proper test administration. I agree that neither the test administrator nor the Haverhill Public Schools, nor any of its trustees, officers, employees, or organization sponsors are liable for any accident or injuries that may occur from participation in the COVID-19 testing program.
G. I acknowledge that a positive **individual** test result is an indication that I must stay home from school, self-isolate, per MDPH guidelines.
H. I understand the school system is not acting as my medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if their condition worsens. I understand I am financially responsible for any care I receive from my healthcare provider.
I. I understand that COVID-19 testing may create protected health information (PHI) and other personally identifiable information, and such information will only be accessed, used, and disclosed in accordance with HIPAA and applicable law. Pursuant to 45 CFR 164.524(c)(3), I authorize and direct the testing provider to transmit such PHI to the Massachusetts Department of Public Health, the Massachusetts Executive Office of Health and Human Services, and the testing laboratory. I further understand that PHI may be disclosed to the Executive Office of Health and Human Services and any other party, as authorized under HIPAA.
J. I understand that participation in COVID-19 testing may require the school to disclose my identity, demographic, and I authorize my school to disclose such personally identifiable information (PII) as is required for my participation in COVID-19 testing.
K. I understand that authorizing these COVID-19 tests for myself is optional and that I can refuse to give this authorization, in which case, I will not be tested.

L. 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 previously released. To cancel this permission for COVID-19 testing, I need to contact building based school nurse or Katie Vozeolas, Director of Health and Nursing (kvozeolas@haverhill-ps.org).

M. I authorize the testing provider and/or the Massachusetts Department of Public Health to monitor aspects of the COVID-19 virus, such as tracking viral mutations, by analyzing positive sample(s) for epidemiological and public health purposes. Results of such analyses will not be personally identifiable nor create personally identifiable information.

I, the undersigned, have been informed about the COVID-19 test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19 for myself.

Print Name:		**Date of Birth:**
Signature:		**Date:**