STUDENT CONSENT FORM FOR VOLUNTARY COVID-19 TESTING

The South Carolina Department of Health and Environmental Control (DHEC) takes the health and safety of students and school staff very seriously. As such, DHEC is partnering with schools to provide voluntary PreK-12 COVID-19 testing for students and school staff.

What is the test?

If you consent, your child will be tested for COVID-19 using the Abbott Laboratories BinaxNOW rapid antigen test. The Abbott BinaxNOW rapid antigen test is a test that indicates if someone currently has COVID-19. A school nurse (RN or LPN) or athletic trainer who has been trained to administer this test will either collect the specimen or will instruct and supervise as the sample is self-collected. To collect the specimen, a swab, similar to a Q-Tip, is placed inside the nostril approximately ½ of an inch deep and rotated against the nostril wall. This is done in each nostril and only takes 10-15 seconds. The results will be ready in approximately 15 minutes.

In some scenarios, a molecular might be recommended to confirm the antigen test result. In addition to BinaxNOW rapid antigen tests, some schools may be able to offer a CUE rapid molecular test. This test sample is also collected using a shallow nasal swab in each nostril. The swab is then inserted into a cartridge which is inserted to a reader. Test results will be delivered via Bluetooth to a secure app on a phone or tablet designated to the test administrator specifically for CUE testing. Results will be ready in 20 minutes.

Safety precautions will be followed prior to, during, and after the test including all proper use of personal protective equipment (PPE), hand hygiene, and cleaning and disinfection of the environment.

What is Asymptomatic Screening?

If you consent, you elect to participate in your school or district's asymptomatic screening, also called serial testing, program. Asymptomatic screening involves routine testing to detect individuals infected with COVID-19 that are asymptomatic. Rapid, point-of care serial screening can identify asymptomatic cases and help interrupt SARS-CoV-2 transmission. In such a program, asymptomatic individuals will be routinely tested using the collection method above. The testing schedule will follow the regimen adopted by your school or district.

TO BE COMPLETED BY PARENT, GUARDIAN, LEGAL CUSTODIAN, FOSTER CARE PROVIDER, STUDENT OVER THE AGE OF 16 OR STUDENT OTHERWISE AUTHORIZED TO PROVIDE CONSENT

Parent/Guardian/Legal Custodian/Foster Care Provider Information

Name: _____

Address: _____

Telephone Number: _____

Email Address: _____

Student Information

Name: _____

Student ID #: _____

Date of Birth: _____

Student Address: _____

Consent

By signing below, I attest that:

- **I have signed this form freely and voluntarily, and I am legally authorized to make decisions for the child named above.**
- **I authorize the school nurse, RN or LPN, or the athletic trainer to conduct or supervise the specimen collection and BinaxNOW testing procedure for COVID-19 through anterior nasal swab for my child as ordered by an authorized DHEC medical provider.**
- **I understand that by providing consent for my child to be tested, I am also authorizing the test result and testing records to be disclosed to DHEC, school contact tracing staff, and Clinical Laboratory Improvements Amendments' inspectors as applicable.**
- **I understand that the school, school district, school staff, DHEC, and DHEC's medical providers are not acting as my child's medical provider. This testing does not replace treatment by my child's medical provider, and I assume complete and full responsibility to take appropriate action with regard to the test result.**
- **I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.**
- **I authorize the school nurse, RN or LPN, or athletic trainer to conduct required additional confirmatory testing if provided by the school.**

- **I acknowledge that a positive test result requires my child to isolate and not come to school for the applicable period of time following a positive test.**
- **I understand that this consent form will be valid for either: (please check all that apply)**
  - ☐ **A single specimen collection**

    OR
  - ☐ **For the duration of the 2021-2022 school year**

    OR
  - ☐ **For routine collection as part of an asymptomatic screening program**
- **I understand that if I elect to allow this consent form to be used for the 2021-2022 school year, I will notify my child's school in writing if I choose to revoke my consent.**
- **I understand that if I am a student age 16 or older, or a student who may otherwise legally consent for my own health care, references to "my child" refer to me and I may sign this form on my own behalf**

Signature of Parent/Guardian/Legal Custodian/Foster Care Provider:
(if child is under the age of 16)

_____ **Date:** _____

Signature of Student:
(if age 16 or over or otherwise authorized to consent)

_____ **Date:** _____

VERBAL CONSENT FORM FOR VOLUNTARY COVID-19 TESTING

Print Student's Name: _____

Parent/Guardian/Legal Custodian/Foster Care Guardian Name Called:

_____

Print Phone Number Called: _____

Please Check One:
☐ **Parent/Guardian/Legal Custodian/Foster Care Provider has a copy of the Student Consent Form for Voluntary COVID-19 Testing and has read it.**
OR
☐ **School Staff read the Student Consent Form for Voluntary COVID-19 Testing to the Parent/Guardian/Legal Custodian/Foster Care Provider.**

Parent/Guardian/Legal Custodian/Foster Care Provider Gave Verbal Consent?
☐ **Yes** ☐ **No**

Print School Staff's Name Receiving Verbal Consent: _____

Signature of School Staff Receiving Verbal Consent: _____

Date Consent Given: _____