STUDENT COVID-19 ANTIGEN TESTING PARENTAL CONSENT FORM

County: ☐ New Castle ☐ Kent ☐ Sussex ☐ Other (please specify): ______________________

Parent/Guardian/Adult Self Information

Name: ____

Address: ____

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Telephone/Mobile Number: __________________________ **Email:** ______________________________

Best Way to Contact You: ☐ Mobile/Cell Phone ☐ Home Phone ☐ Email

Student/Adult Self Information (*Person receiving Antigen testing)*

Name: ____

Date of Birth: ______________________________ **Sex:** ☐ Male ☐ Female

Race: ☐ White ☐ Black/African American ☐ Asian or Pacific Islander ☐ American Indian or Alaska Native ☐ Multiracial

☐ Other: ______________________________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

School: ______________________________ **Grade:** ________

Cohort: ☐ Cohort A (In person Monday & Tuesday) ☐ Cohort B (In person Thursday & Friday)

☐ Cohort C (In person Monday, Tuesday, Thursday & Friday)

NOTIFICATION OF INFORMATION SHARING:

The law allows some information about your child to be shared with certain Delaware State agencies and their contracted service providers, including Christina School District, Delaware Department of Education, Delaware Division of Public Health (DHSS – DPH) and staff conducting COVID-19 Antigen Testing. This information will be shared only for public health purposes, which may include notifying close contacts of your child if they have been exposed to COVID-19, and taking other steps to prevent the further spread of COVID-19 in the community. Information about your child that may be shared with these agencies and service providers conducting COVID-19 Testing includes your child's name, COVID-19 test results, date of birth/age, gender, race/ethnicity, school name(s), teacher(s), classroom/ cohort/pod, enrollment and attendance history, and afterschool or other program participation, names of other family members or guardians, address, telephone, mobile number, and email address. Sharing of information about your child will only be done so in accordance with applicable law and policies protecting student privacy and the security of your child's data.

CONSENT By checking each box 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, or myself.

☐ I consent for my child/adult self to be tested for COVID-19 infection.

☐ I consent for my child or adult self to be tested for COVID-19 infection. I understand that my child or adult self may be tested at multiple times through September 30, 2021, and that testing may occur on days scheduled by the Christina School District.

☐ I understand that this consent form will be valid through September 30, 2021, unless I notify the designated contact person from my child's school in writing that I revoke my consent.

☐ I understand that if I am a student age 18 or older, or 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/Adult Self (Parent must sign if child is under age 18): ______________________________

By submitting this form, I understand that I am giving my consent for my student or myself if 18 years of age, to be selected to receive a free diagnostic test for the COVID-19 virus and I understand and agree with the Notification of Information Sharing set forth above.