FREMONT COUNTY SCHOOL DISTRICT NO. 2

Every Day Counts: Educate, Engage, Empower

FCSD #2 Student COVID-19 Testing Consent Form

Please read:

FCSD #2 is offering voluntary COVID-19 testing and the Test to Stay option for students. At this time, FCSD#2 will be testing **asymptomatic** students only. This is a free service to our students.

If your child has any COVID-19 symptoms and you would like them to be tested, please keep them home from school, notify the school, and see your healthcare provider. The WDH still recognizes the following, but not limited to, as common symptoms of the COVID-19 virus:

Fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, the new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea.

FCSD #2 is currently using the antigen (rapid) testing system called *CUE. CUE* is a shallow nasal swab test. The results take about 25 minutes.
Positive results will be reported to the WDH. Results will be sent via email, phone or text when available and in a timely manner.

Please complete this form for the individual being tested before the first test:

First Name:_____ Last Name:_____

Date of Birth: _____

Address: _____

City/State/Zip: _____

Parent/Guardian Information:

Name:_____

Cell Phone:_____ OK to text results: Y__ N__ This is not secure

Email:_____

Please see the reverse side for consent ⟶

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By signing below:

- I authorize FCSD #2 to test my child for COVID-19.
- I understand that like any medical test, there is potential for a false positive or negative result.
- I authorize the test results to be released for the **sole purpose** of identifying others who may have been exposed. I understand my child's test results will go to Fremont County Health Department and to any other governmental entity the law requires.
- I assume complete and full responsibility to take appropriate action with regard to my child's test results. If my child tests positive, I will adhere to FCSD #2 student illness policy and protocol.
- I understand that testing does not replace treatment by a medical provider.
- I understand that I am able to withdraw this consent at anytime
- I understand this consent form is valid until May 27, 2022

_____ Date: _____

Signature of Student (18 years of age or older)

_____ Date: _____

Parent/Guardian Signature (If minor)

Test Result: _____
Tester Initial: _____
Date: _____
Notification Date/Initial:
_____

Test to stay dates:

Day1:
Day 2:
Day 3:
Day 4:
Day 5: