Consent For COVID-19 Testing

Patient Name: _____ DOB: _____

What is this form?
We are seeking your consent (permission) for two types of FREE COVID-19 tests that will be used in Schenectady County schools during the 2021-2022 school year. **Please return this form to the school office.**

What kinds of tests are being used?
Rapid antigen testing using nasal swabs (non-invasive, painless, self-administered nasal swab at the front of the nostril) and polymerase chain reaction (PCR) testing using saliva swabs (non-invasive, painless, self-administered swab of the inside of the mouth). Abbott BinaxNow COVID-19 Ag Cards are being used for rapid antigen testing. Quadrant Laboratories LLC is engaged to perform COVID-19 testing of saliva specimens.

The testing may be for screening and/or diagnostic purposes related to the SARS-CoV-2 virus. For screening purposes, your child's saliva specimen may be combined with saliva specimens from other individuals into a single pool for testing. If the pool that contains your child's saliva specimen tests positive for SARS-CoV-2, all specimens in the pool will be individually tested for SARS-CoV-2 because pooled testing does not identify which specimen or specimens were positive.

How often will you test my child?
The school will test some of the students, teachers, and staff on a weekly basis. If you consent, your child may be selected for testing on one or more of these testing days. Testing is being offered to all students if they exhibit one or more symptoms of COVID-19; if they are a close contact of a student, teacher, or staff person with COVID-19 infection; or in connection with their participation in an extracurricular activity for which testing may be conducted.

How will I know if my child tests positive?
Rapid antigen test results will be available fifteen minutes after the test is completed. The school nurse will make you aware of any positive result. PCR test results will be available about 24-48 hours after the specimens have arrived at the lab and the school nurse will call parents/guardians of all positive students.

By consenting for COVID-19 testing, you are authorizing Quadrant Laboratories to:

- Use the information that is provided by you or Your School together with the saliva specimen to perform screening or diagnostic testing for SARS-CoV-2. The SARS-CoV-2 testing will be done using Quadrant's Clarifi COVID-19 Test assay, which has received Emergency Use Authorization from the FDA.
- Store the information that you provide as part of the registration process and your pooled and individual test results in a secure database ("Your Information").
- Release and transmit Your Information to your health care provider, Your School, the New York State Department of Health, and any other federal, state, county, or city health department or agency that is entitled by law to receive the information for public health purposes.
- Release and transmit Your Information as necessary to submit claims for payment or reimbursement for any diagnostic tests performed on your saliva specimen to your health insurance carrier, government health program, or any other third-party payors you provide information for.

By consenting for COVID-19 testing, you are authorizing the use of BinaxNow COVID-19 Ag Cards with your student.

- The test is a non-invasive, painless, self-administered nasal swab at the front of the nostril.
- It provides results in 15 minutes. The students' parent or guardian will be notified immediately of a positive result.
- Depending on the result and the students' symptoms (or lack of symptoms), a follow up saliva swab may then be done to confirm rapid result.

By consenting and registering for this testing, you are also authorizing Your School to access the information that

you provide through the registration process to schedule and order testing, and to collect saliva specimens, or nasal specimens to be used in the testing.

This authorization will remain in effect until the end of the 2021-2022 school year or until rescinded.

Schools Name: _____

Signature: _____
(Signature of patient or legal representative if patient is a minor)

Print Name: _____

Relationship to patient: _____

Date: _____

To Register Your Student(s), fill out online forms located here: app.Clarifi-COVID-19.com

If you prefer that the school register your student(s), please fill out pages 3-5.

*** Indicates you must provide a response for the information requested.**

Personal Information:

*Child's First Name (must be legal first name):_____

Child's Middle Name:_____

*Child's Last Name: _____

*Sex: Male/Female/Other

*Date of Birth (MM/DD/YYYY):_____

*Race (circle one):

White or Caucasian
Black or African American
American Indian or Alaska Native
Asian
Native Hawaiian and Other Pacific Islander
Other
Decline to Answer
Unknown
Asian Indian
Chinese
Filipino
Japanese
Korean
Vietnamese
Other Asian
Native Hawaiian
Guamanian or Chamorro
Samoan
Other Pacific Islander
Bangladeshi
Bhutanese
Burmese
Cambodian
Taiwanese
Hmong
Indonesian
Laotian
Malaysian
Okinawan
Pakistani
Sri lankan
Thai
Iwo Jiman
Maldivian
Nepalese
Singaporean
Madagascar
Tahitian
Tongan
Tokelauan
Mariana Islander
Marshallese
Palauan
Carolinian
Kosraean
Pohnpeian
Saipanese
Kiribati
Chuukese
Yapese
Melanesian
Fijian
Papua New Guinean
Solomon Islander
New Hebrides
Guamanian
Chamorro

*Ethnicity (circle one):

Not Hispanic
Decline to Answer
Puerto Rican
Cuban
Another Hispanic, Latino/a, or Spanish Origin
Spaniard
Andalusian
Asturian
Castillian
Catalonian
Belearic Islander
Gallego
Valencian
Canarian
Spanish Basque
La Raza
Mexican American Indian
Central American
Costa Rican
Guatemalan
Honduran
Nicaraguan
Panamanian
Salvadoran
Central American Indian
Canal Zone
South American
Argentinean
Bolivian
Chilean
Colombian
Ecuadorian
Paraguayan
Peruvian
Uruguayan
Venezuelan
South American Indian
Criollo
Latin American
Dominican
Mexican
Mexican American
Mexicano
Chicano

Current Address:

*Phone Number: _____

*Current Address: _____

*City: _____

*County:_____

*State: _____

*ZIP Code: _____

Legal Address:

*Legal Address (if different from Current Address): _____

*City: _____

*County: _____

*State: _____

*ZIP Code: _____

Student/Employer Information:

*Employment Status (circle one):

Full Time
Part Time
Retired
Student – full time
Student – part time
Unknown

*Employer Name or School Name: _____

Employer Address: _____

City: _____

State: _____

ZIP Code: _____

Insurance Information:

Does the patient have insurance? (Circle one)

Yes
No

If Yes, Relationship to subscriber (circle one):

Child
Self
Adopted Child
Brother or Sister
Brother-in-law or Sister-in-law
Cadaver Donor
Child Where Insured Has No Financial Responsibility
Collateral Dependent
Court Appointed Guardian
Cousin
Dependent of a Minor Dependent
Emancipated Minor
Employee
Ex-spouse
Father
Foster Child
Grandfather or Grandmother
Guardian
Injured Plaintiff
Life Partner
Mother
Mother-in-law or Father-in-law
Niece or Nephew
Organ Donor
Other Adult
Other Relationship
Parent
Significant Other
Son-in-law or Daughter-in-law
Sponsored Dependent
Spouse
Stepfather
Stepmother
Stepson or Stepdaughter
Uncle or Aunt
Ward
Handicapped Dependent

The subscriber is financially responsible for the patient? (Circle one)

Yes
No

Insurance Company (if applicable)

*Company Name: _____

*Company Address:_____

*Company Phone: _____

*Subscriber ID: _____

Subscriber group #: _____

*Subscriber First Name: _____

*Subscriber Last Name: _____

*Subscriber Address: _____

*Subscriber Phone: _____

*Subscriber Employer: _____