



COVID-19 Testing - Informed Consent

Full Name: _____ **PSD Staff or Student:** _____

Birth Date: _____ **Staff/Student ID#:** _____

The Pasco School District has partnered with the Benton-Franklin Health District (BFHD) and the WA State Department of Health (DOH) to offer free, voluntary COVID-19 testing. Please carefully read and sign the following Informed Consent:

- I authorize designated Pasco School District COVID-19 COVID-19 test observers to facilitate collection and testing for COVID-19 through an oral or nasal swab on the following date(s): _____.
- I understand that my ability to receive testing is limited to the availability of test supplies.
- I acknowledge that a positive test result is an indication that I must isolate and/or wear a face covering as directed in an effort to avoid infecting others.
- I understand that by administering the test, the Pasco School District is not acting as my medical provider, and that this testing does not replace treatment by a medical provider. I assume complete and full responsibility to take appropriate action regarding my test results and my medical care. I agree I will seek medical advice, care and treatment from my medical provider if I have any questions or concerns, develop symptoms of COVID-19, or if my condition worsens.
- I understand that, as with any medical test, there is a potential for a false positive or false negative COVID-19 test result.
- I have been informed of the test purpose, procedures, and potential risks and benefits. I will have the opportunity to ask questions before proceeding with a COVID-19 test. I understand that if I do not wish to continue with the COVID-19 diagnostic test, I may decline to test.
- I authorize the test results to be disclosed to public health officials, the county, state, or to any other governmental entity as required by law.
- I understand that to ensure public health and safety and to control the spread of COVID-19, my test results may be shared without my individual authorization.
- I understand that I may withdraw my consent to participate in testing at any time.

I, the undersigned, have been informed about the 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.

___ I agree to authorize my student to undergo COVID-19 Testing

Parent/Guardian Name (Please Print)	Parent/Guardian Signature	Date
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___ I agree to undergo COVID-19 Testing

Name (Please Print)	Signature	Date
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