



# Binghamton Consent/Refusal for COVID-19 Testing 2020-21

## CONSENT/REFUSAL FORM FOR COVID-19 TESTING

### What is this form?

We are seeking your consent to test your child for COVID-19 infection. The Binghamton City School District is working with UHS to test Binghamton City Schools District students, staff and teachers.

### How often would you test my child?

Your child may be tested throughout the school year in accordance with state and county health departments such as weekly testing in schools in Yellow Zones. We are arranging for testing to come to every school at least once a week to test some of the students and staff. If you consent, your child may be selected for testing on one or more of these occasions.

### What is the test?

**If you consent**, your child will receive a free diagnostic test for the COVID-19 virus. Collecting a specimen for testing involves inserting a small swab, similar to a Q-Tip, into the front of the nose.

### How will I know if my child tests positive?

If your child has a specimen collected for testing at school, we will email you the results within 24 hours.

### What should I do when I receive my child's test results?

If your child's test results are positive, please contact your child's doctor immediately to review the test results and discuss what you should do next. You should keep your child at home. If your child's test results are negative, this means that the virus was not detected in your child's specimen. Tests **sometimes** produce incorrect negative results (called "false negatives") in people who have COVID-19. If your child tests negative but has symptoms of COVID-19, or if you have concerns about your child's exposure to COVID-19, you should call your child's doctor.

## TO BE COMPLETED BY PARENT, GUARDIAN OR ADULT STUDENT

### Parent/Guardian Information

Parent/Guardian Print Name:	
Parent/Guardian Address:	
Parent/Guardian Tel./Mobile #:	
Parent/Guardian Email address:	
Best way to contact you:	

### Child/Student Information

Child/Student Print Name:	
Child/Student Date of Birth:	
Child/Student School:	
Child/Student Address:	

## NOTIFICATION OF INFORMATION SHARING

The law allows some information about your child to be shared with and among certain County and New York State agencies, as noted below. 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 your school community. Information about your child that may be shared includes your child's name and COVID-19 test results, date of birth/age, gender, race/ethnicity, school name(s), teacher(s), enrollment and attendance, 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 Binghamton City School District policies protecting student privacy and the security of your child's data.

- NYS Department of Health
- Contracted Service Providers for COVID-19 Testing
- Broome County Health Department

## 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 consent for my child to be tested for COVID-19 infection.
- I understand that my child may be tested at multiple times through June 30, 2021.
- I understand that this consent form will be valid through June 30, 2021, unless I notify the designated contact person from my child's school **in writing** that I revoke my consent.
- I understand that my child's test result's and other information may be disclosed as permitted by law.
- 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* (if child is under age 18)	Date
Signature of Student (if age 18 or over or otherwise authorized to consent)	Date

## REFUSAL

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 do NOT give permission for my child to be tested for COVID-19 infection.
- I understand that this refusal form will be valid through June 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* (if child is under age 18)	Date
Signature of Student (if age 18 or over or otherwise authorized to consent)	Date