



**STUDENT COVID-19 TESTING CONSENT FORM – DUNHAM SCHOOL DISTRICT**

|   |       |               |            |              |
|---|-------|---------------|------------|--------------|
| Name of Student participating in testing (hereafter “Student”): |       | DOB           | Sex        | Student ID # |
| Name of Parent/Legal Guardian (if Student under 18)             |       | School/Grade: |            |              |
| Address:  | City: | Zip:          | Telephone: |              |

I certify that I am: (a) the Student and at least 13 years of age; (b) the legal guardian of the Student; or (c) a person authorized to consent on behalf of the Student where the student is not otherwise competent or unable to consent for themselves.

I hereby give my consent to the Dunham School District (the “District”), as applicable (each an “applicable Provider”), to provide COVID-19 testing to the Student listed above.

On behalf of the Student, the Student’s heirs and personal representatives, I hereby waive any claim I may have against the District, and its governing board, officers, agents, employees, volunteers, and representatives (“Released Parties”) from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the COVID-19 testing.

I acknowledge that: (a) I understand the purposes/benefits of my county’s testing registry (“Registry”) and my state’s Health Information Exchange (“State HIE”); and (b) the applicable Provider may disclose Student’s testing information to the county testing records, to the State HIE, or through the State HIE to the county testing records, or to any state or federal governmental agencies or authorities (“Government Agencies”), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Centers for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to Student’s healthcare providers enrolled in the county testing records and/or State HIE for purposes of care coordination.

**I confirm that Student has no known medical conditions that may pose a risk to the health and safety of Student in connection with the testing that is the subject of this agreement.**

I acknowledge that I have had a chance to ask questions about the COVID-19 testing. I understand the known risks and the potential benefits of receiving the COVID-19 testing, and I understand that there may be risks to the COVID-19 testing that are not known at this time. I nonetheless request and consent to the COVID-19 testing being given to Student. I acknowledge that receipt of this testing is voluntary on my part and is provided at no charge to me. I agree to hold the District, and its agents, harmless from any injury or loss resulting from Student’s receipt of the COVID-19 testing.

I HAVE READ THIS WAIVER OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT. I FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Printed Name: \_\_\_\_\_