STUDENTS ONLY

COVID-19 BinaxNOW Antigen Testing Consent Form

And Waiver and Release of Claims

Dear Parents/Guardians:

Your child may be eligible to receive a nasal swab BinaxNOW antigen test if he/she is showing symptoms of COVID-19. Symptoms may include: cough, fever, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting or diarrhea. If you agree to allow your child to receive the BinaxNOW antigen test if he/she is showing symptoms of COVID-19 at any time while on campus for the duration of this consent, please complete the following information:

Student Name: ____________________ **DOB:** ____________

School: ___________________________ **Grade:** ___________

Email: ____________________________ **Phone:** ________________

Address with City/Zip: _______________________________________

Parent/Guardian Name(s): ___________________________________

Other Vail staff or students in household (if applicable, list their first/last name and school):

____

(Initial each line separately. Every line must be initialed for consent to be valid):

a. ____ I authorize Vail School District trained personnel to administer the COVID-19 BinaxNOW antigen test to my child.

b. ____ I understand that this is an ongoing consent to administer the BinaxNOW antigen test to my child and that I will not be contacted to provide additional consent prior to administration of the test should my child have symptoms of COVID-19 while on campus.

c. ____ I understand that all test results will be disclosed to county and state health officials and designated school officials.

d. ____ I understand that there is the potential for a false positive or false negative COVID-19 test result.

e. ____ If my child has symptoms, I have been informed that a negative test will not necessarily rule out infection or COVID-19 and my child will still be required to follow Vail School District procedures for symptoms consistent with COVID-19.

Waiver of Liability and Release of Claims:

In providing my consent for the District to administer the BinaxNOW antigen test to my child, and to the fullest extent permitted by law, I hereby agree to waive, release, and discharge any and all claims, causes of action, damages, and rights of any kind against the District, its insurers, the District's Governing Board, and all of their respective employees, agents, representatives, and volunteers (the "Released Parties") arising from or relating in any way to any damage, injury, trauma, illness, loss, disability, or death that may occur to my child, me, or my household members as a result of the test administration or a false negative/false positive test result from the District's administration of the COVID-19 BinaxNOW antigen test to my child.

I further agree not to sue the Release Parties, and to defend and indemnify the Release Parties for all claims, damages, losses, or expenses, including attorney's fees, if a lawsuit is filed concerning an injury, illness, or death to me, my child, or my household members as a result of the test administration or a false negative/positive test result from the District's administration of the COVID-19 BinaxNOW antigen test given to my child.

BY MY SIGNATURE BELOW, I AGREE TO THE ADMINISTRATION OF THE COVID-19 BINAXNOW ANTIGEN TEST BY DISTRICT PERSONNEL TO BE PROVIDED TO MY CHILD

Parent/Guardian Name (Printed): ______________________________

Parent/Guardian Signature: ___________________________________

Date: _________________

This Consent Form must be completed and on file in the health office for your child to receive antigen testing. This Consent Form is only valid during the 2020-2021 school year, through June 30, 2021.

Review the BinaxNOW Fact Sheet here:
https://www.fda/gov/media/141569/download

DISTRICT USE

TEST RESULTS

____NEGATIVE ____POSITIVE

Date and time of test: _______________ Administered by: _______________