CONSENT FOR PCR SALIVA TESTING
WESTCHESTER COUNTY SCHOOLS COVID-19 SCREENING TESTING PROGRAM

Student\Teacher\Staff Person's Name:____

Student Grade________ **School Name:**____

Student\Teacher\Staff Person's Address:____
City/State:____**Zip Code:**____________
Date of Birth:______________________________ **Sex:** _________________________________

Race (circle all that apply):
American Indian or Alaskan Native
Black or African American
White
Asian
Native Hawaiian/Pacific Islander
Other
Unknown

Ethnicity (circle one):
Hispanic or Latino
Non-Hispanic or Latino
Unknown

Has your child/you tested positive for COVID-19 in the last 90 days? YES______ NO_______
If YES, date of positive test: _______________________

- I authorize the Westchester County Department of Health, (the "WCDH") and it contractors to receive self-collected saliva samples on the above named individual and conduct COVID-19 screening tests on those samples.
- I have read and understand the attached Frequently Asked Questions about the Westchester County Schools COVID-19 SCREENING TESTING PROGRAM (the "Program"). I understand there will be no cost to me for this testing Program. I authorize the release of information as indicated in the Frequently Asked Questions as part of the Program for public health purposes.
- By signing this, I am giving permission for my child/legal guardian or myself to participate in this voluntary testing Program.
- I understand that I have the right to revoke this consent at any time by notifying in writing the school nurse or whomever the school designates in writing to receive such notice.
- I understand that if my child/legal guardian/I have tested positive for COVID-19 within the last 90 days, my child/legal guardian/I will not be able to participate in the Program until 90 days has passed since the positive test result.
- I understand and acknowledge that WCDH, its contractors, and the school/district are not acting as the medical provider and this Program is not for testing if a person is sick or exposed to a person with COVID-19. I will receive positive test results and will take appropriate actions.

I have read this form and all of my questions have been answered to my satisfaction. By signing this form, I acknowledge that I have read and accept all of the above.

____

Signature of Student, Parent/Guardian if Student is under the age of 18, Teacher or Staff Person
Print Name:____
Parent/Guardian relation to Student if Student is under the age of 18:_________________________
Parent/Guardian Tele: if Student is under the age of 18:_________________________________
Date:____

AUTHORIZATON TO DISCLOSE PROTECTED HEALTH INFORMATION (COVID TEST RESULTS)

____

Student\Teacher\Staff Person's Name: ____

Student\Teacher\Staff Person's Address:____

City/State:____**Zip Code:**________________

Date of Birth:_____________________________________
Tele:_____________________________________

I authorize Westchester County Department of Health and its testing partners (Mount Sinai Health Systems, Inc., Mirimus Inc. and Quadrant Biosciences, Inc.) to disclose the above named individual's health information as follows:

Name and address of person(s)/entity to whom this information is to be sent ("Recipient"):
Name: ______________________________ SCHOOL DISTRICT
Address:______________________________

Description of Information to be disclosed: The COVID-19 PCR SALIVA TEST RESULTS ("COVID Information") of the above named individual.

Purpose of Disclosure: PARTICIPATION IN WESTCHESTER COUNTY SCHOOLS COVID-19 SCREENING TESTING PROGRAM and SCHOOL ATTENDANCE

This authorization will expire one year from the date on which it was signed.

This authorization permits the release of COVID information of the above-named individual to the above-named Recipient on an ongoing basis for however many COVID tests such individual undergoes before the expiration of this authorization.

1. I understand that any disclosure/release is bound by the Health Insurance Portability and Accountability Act of 1997 (HIPAA) 45 C.F.R. pts 160 & 164; and re-disclosure of this information to a party other than one designated above is forbidden without written authorization on my part, unless required or permitted under law or regulation.

2. I understand that the WCDH and its Testing Partners have no ability to prevent re-disclosure of my COVID information by Recipient.

3. Signing this authorization is voluntary. I understand that I have the right to revoke this authorization at any time, except to the extent that WCDH and its Testing Partners have already acted in reliance on it. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school nurse or whomever the school designates in writing to receive such notice.

I have read this form and all of my questions have been answered to my satisfaction. By signing this form, I acknowledge that I have read, understand and accept all of the above.

____
Signature of Student, Parent/guardian if Student is under the age of 18, Teacher or Staff Person

Print Name:____
Parent/Guardian relation to Student if Student is under the age of 18:____________________________________
Parent/Guardian address if Student is under the age of 18:____
Parent/ Guardian email address if Student is under the age of 18:____________________________________
Parent/Guardian Tele: if Student is under the age of 18:____
Date: ____