

Parent/Guardians/Caregivers/Staff

Consent to COVID-19 Test

Please carefully read and provide written acknowledgment of the following informed consent:

- I authorize a COVID-19 testing administrator associated with LaCrosse Schools, local health department or state health department to conduct collection and testing for COVID-19 through a nasal or nasopharyngeal swab collection as deemed appropriate for the purpose of:
 - My student is exhibiting symptoms that can be associated with the COVID-19 virus.
 - My student is considered a close contact and desires to stay and learn.
 - My student is considered a close contact and desires to stay and play.

- I understand by signing this document that I am giving permission for diagnostic screening to be conducted as needed during the 2021-2022 school year or until I have notified the school, in writing, that my consent is being withdrawn.
- I authorize my test result, or the test result of my child if my child is under the age of 18 years, to be disclosed to the county, state, or to any other governmental entity as may be required by law.
- I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.
- I give permission for the Rush County Health Dept. and my school district to contact me using non-secure methods (e-mail or phone) regarding this COVID-19 test result, and I understand the risks involved.

Student(s) Name: _____

(If giving consent for more than one student please add names below.)

Signature of Parent/Guardian/Staff: _____

Date: _____