STUDENT/ STAFF CONSENT FORM FOR OPTIONAL COVID-19 TESTING BY LAKE OF THE WOODS SCHOOL

The Lake of the Woods School District takes the health and safety of our students, staff and their families very seriously. As such, in addition to steps to screen for the virus and prevent its spread at school, we are adding a voluntary COVID-19 testing program for students and staff. This program primarily uses CUE tests and, under certain circumstances, the Midwest Coordination Center Pool Test. We will only test with your consent. If you are willing to provide consent for us to administer this test on yourself or your child, please fill out this form.

What is the test?

The Cue test is an individual, diagnostic molecular COVID-19 test that uses a nasal swab. Results are available within 20 minutes of processing. The Minnesota Department of Health (MDH) has received a limited supply of Cue tests through a grant by the U.S. Department of Health and Human services. These tests have been made available to schools at no cost.

The Pool test is a screening test intended to identify COVID-19 cases in people who are asymptomatic or before people develop symptoms. The pooled testing utilizes a nasal swab. Specimens are pooled into groups of five to 10 test processing. Pools can be assigned at the classroom level and at the staff level. If there is a positive result within the pool, everyone in that pool should isolate until an individual cue test can be completed.

This program is **entirely optional** and is being offered in addition to existing safety protocols such as recommended mask-wearing, social distancing, and frequent disinfection of surfaces.

Known Symptoms:

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear **2-14 days after exposure to the virus.** People with these symptoms may have COVID-19:

Feeling feverish or a measured temperature greater than or equal to 100.0 degrees Fahrenheit			
Loss of taste or smell	Cough	Difficulty breathing	Sore throat
Shortness of breath	Fatigue	Headache	Congestion or runny nose
Chills	Shaking or shivering	Significant muscle pain / ache	Nausea/ vomiting or diarrhea

This list does not include all possible symptoms.

Disclaimer:

While we realize precautions will be taken for the safety of students, please understand that neither the test administrator nor Lake of the Woods Independent School District, nor any of its employees are liable for any accident or injuries that may occur to your child or yourself (if student age 18 or older), as a result of agreeing to the test.

TO BE COMPLETED BY PARENT, GUARDIAN OR ADULT STUDENT

You will be notified with test results either via cell phone or email, or both.

Parent/Guardian Print Name:	
Parent/Guardian Cell/Mobile #:	
Parent/Guardian Email Address:	

Student/ Staff Information					
Student/ Staff Print Name:					
Student/ Staff ID number:					
Grade Level and Age:					
Date of Birth: *(MM/DD/YYYY)*					
Address:		**City:**		**Zip Code:**	
Race (pick one):	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Prefer not to say				
Ethnicity (pick one):	☐ Hispanic or Latinx ☐ Not Hispanic or Latinx ☐ Prefer not to say	**Gender:**	☐ Male ☐ Female ☐ Prefer not to say		

CONSENT

By signing below, I attest that:

A. I authorize the school system to conduct collection and testing of my child or myself (if student age 18 or older) for COVID-19 by nasal swab.

B. I acknowledge that a positive test result is an indication that my child or myself (if student at age 18 or older), must self-isolate and also continue wearing a mask or face covering as directed in an effort to avoid infecting others.

C. I understand the school system is not acting as my child's medical provider, this testing does not replace treatment by my child's medical provider, and I assume complete and full responsibility t o take appropriate action with regards to my child's test results. I agree that I will seek medical advice, care and treatment from my child's medical provider if I have questions or concerns, or if their condition worsens.

D. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

E. I understand the School Nurse will have access to my results to assist with contact tracing

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19.

Signature of Parent/ Guardian:		**Date:**
Signature of Student: *(if age 18 or over or otherwise authorized to consent)*		**Date:**