Horseheads Central School District
Consent for STAFF COVID-19 Testing

The Horseheads Central School District (the "District") is seeking consent to test you for COVID-19 infection. If you consent, you will be tested using a diagnostic test for the purposes of the Test to Stay option. The diagnostic test involves inserting a small swab, similar to a Q-Tip, into the front of the nose.

We will notify you if you test positive for COVID-19. Anyone who tests positive must return home and must stay at home until meeting Health Department and District criteria for return to school. Please contact your medical provider immediately if you test positive for COVID-19.

Student Information:

Name _____

Address _____

Date of Birth _____ Student Grade _____

Location of Employment (please circle one): BF CS GR RR IS MS HS Trans. Facilities

Race (please circle one):

American Indian/Alaskan Native *Asian* *Black* *Native Hawaiian/Other Pacific Islander* *White*

Ethnicity (please circle one): **Gender (please circle one):**

Hispanic *Non-Hispanic* *Male* *Female* *Non-Binary*

The law allows some of your information to be shared with Chemung County and New York State public health agencies. This includes notifying the Chemung County Health Department about the results of testing, including the your name, date of birth, race, ethnicity, gender, address, phone number, and result of the COVID-19 rapid test.

By signing below, I attest that:

- I have signed this form freely and voluntarily, and I am legally authorized to make decisions for myself.
- I authorize the Horseheads Central School District to test me for COVID-19 infection.
- I understand that I may be tested at multiple times during the 2021-2022 school year.
- I understand that this form will be valid through June 30, 2022 unless I revoke such consent in writing.
- I authorize my test results and other information to be disclosed to any governmental entity as may be required or permitted by law.
- I acknowledge that a positive test result will require me to be sent home from school and remain at home until I meet the criteria to return to work according to the Chemung County Health Department and the District.
- I understand that this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action regarding my test results. I agree that I will seek medical advice, care, and treatment for myself from my medical provider if I have questions or concerns, or if I become ill or my condition worsens.
- I understand that, as with any medical test, there is the potential for a false positive or false negative result.

_____ _____ _____

Signature of Staff Member *Please print name* *Date*

Exposure Date: _____

Testing Day	1	2	3	4	5	6	7	8	9	10
Dates Tested										
Initials										