FLAGSTAFF UNIFIED School District

McKenzie Bevirt
Chief Health Administrator

STUDENTS ONLY

Covid-19 BinaxNow Antigen Testing Consent Form And Waiver and Release of Claims

Dear Parents/Guardians:

While at school, 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 would like your child to receive the BinaxNOW antigen test if he/she is showing symptoms of COVID-19, please complete the following information:

Student Name: ____ **DOB:** _____________ **Grade:** __________

Parent/Guardian Name(s): ____

School: ____

Home Phone: __________________________________ **Cell Phone:** __________________________________

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

a. ____________ I authorize the nurse or other trained administrative staff within FUSD to administer the COVID-19 BinaxNOW antigen test to my child.
b. ____________ I understand that all test results will be disclosed to county and state health officials and designated school officials.
c. ____________ I understand that there is the potential for a false positive or false negative COVID-19 test result.
d. ____________ 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 may still be required to remain at home until he/she can safely return to a school campus.

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 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 Released Parties, and to defend and indemnify the Released Parties for all claims, damages, losses, or expenses, including attorneys' 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/false 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: ______________

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

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