

**GRAND ISLAND CENTRAL SCHOOL DISTRICT
STUDENT COVID-19 TESTING CONSENT FORM**

Student Name: _____

DOB: _____

The State of New York has determined that the Grand Island School District is located within an “Orange Zone,” as defined by the New York State Cluster Action Initiative. As a result, weekly testing of students and staff is required due to elevated rates of COVID-19 transmission in the area. The District is **required** to test 20% of in-person students over the course of a month for as long as the District remains in a designated “Orange Zone” or until the State modifies or lifts the zone requirements.

In order to test your child, we need your consent. Students will be selected on a random basis each week, so if your child is selected one week, they may or may not be tested the following week. All testing will be performed following New York State Department of Health (“DOH”) guidelines and administered by our school nurses.

If tested, some information about your child must be shared with the DOH and any contracted service providers for COVID-19 Testing, including your child’s name and COVID-19 test results and any other data required by the Commissioner of Health. This information will be shared with the DOH for public health purposes, such as contact tracing. If any member of the school community tests positive during this process, the District will continue to follow the guidelines as outlined within the DOH and New York State Education Department reopening guidance.

Please check the correct box below, sign, date, and return this form as soon as possible to your child’s school. Specific instructions for returning this form will be coming from your child’s building principal.

I consent for my child to be tested for the COVID-19 virus.

- I have signed this form freely and voluntarily, and I am legally authorized to make decisions for the child named above;
- I understand that my child may be tested multiple times;
- I understand that this consent form will be valid through June 30, 2021, unless I notify the District in writing that I revoke my consent; and
- I understand that my child’s test results and other information may be disclosed as permitted by law.

I **do not** consent for my child to be tested for the COVID-19 virus.

**GRAND ISLAND CENTRAL SCHOOL DISTRICT
STUDENT COVID-19 TESTING CONSENT FORM**

For students who are 18 years of age or older.

I am a student age 18 or older, or may otherwise legally consent for my own health care. References to “my child” refer to me and I may sign this form on my own behalf. I consent to be tested for the COVID-19 virus.

I am a student age 18 or older, or may otherwise legally consent for my own health care. References to “my child” refer to me and I may sign this form on my own behalf. I **do not** consent to be tested for the COVID-19 virus

Signature of Parent/Guardian (if child is under age 18)

Date

Print Name

Signature of Student (if age 18 or over or otherwise authorized to consent)

Date

Print Name

Address: _____

Telephone Number: _____

Email Address: _____