SHIELD ILLINOIS
STUDENT CONSENT FORM FOR COVID-19 TESTING & RELEASE OF RECORDS

What is this form?

We are seeking your consent to test your child for COVID-19 infection. Berkeley School District 87 ("School District") has partnered with the University of Illinois to test School District students and staff for COVID-19 infection using the University of Illinois' rapid rtPCR test ("SHIELD Test").

Testing will not be administered unless this form is signed**.**

How often will my child be tested?

In accordance with current Centers for Disease Control (CDC) recommendations, as adopted by the Illinois Department of Public Health, testing will be conducted at least one time per week.

What is the test?

If you consent, your child will receive a free SHIELD Test, which is a test for the COVID-19 virus conducted by collecting saliva (spit). The University of Illinois has engaged Preventive Health Partners, SC and Passport Enterprises, LLC to facilitate and administer SHIELD testing.

How will I know if my child tests positive?

The University of Illinois will provide all test results to the School District. If your child's results are positive, you will be contacted by the School District, Preventive Health Partners, SC or Passport Enterprises, LLC. You will not be contacted if your child's results are negative.

What should I do when I receive my child's test results?

If your child's test results are positive, please contact your child's doctor immediately to review the test results and discuss next steps. Your child must be isolated consistent with guidance from the Illinois Department of Public Health.

If your child's test results are negative, this means that the COVID-19 virus was not detected in your child's saliva (spit). Tests sometimes produce incorrect negative results called "false negatives" in people who have COVID-19. If your child tests negative but has symptoms of COVID-19, or if you have concerns about your child's exposure to COVID-19, you should call your child's doctor and isolate consistent with the guidance from the Illinois Department of Public Health.

Who will receive my child's test results?

Testing results will be available to any employees of the School District with a legitimate educational interest, consistent with the Illinois *School Student Records Act*. Additionally, the School District will share the following information in the manner described below:

- The School District may share the following with the Illinois Department of Public Health and the Cook County Health Department: your student's positive and negative test results, name, date of birth, sex, race, ethnicity, and address. The purpose of this disclosure is to facilitate contact tracing and for reporting purposes.

- The School District may share the following with the University of Illinois, Preventive Health Partners, SC and Passport Enterprises, LLC Preventive Health Partners, SC: your student's specimens, positive and negative test results, name, date of birth, address, sex, student identification number, email address, mobile phone, school, race, and ethnicity. The purpose of this disclosure is to facilitate test processing and results, billing, contact tracing, and tracking of test usage.

- The School District may share positive and negative test results and student identifying information with the student and his/her parent/guardian, and as otherwise permitted by law or guidance.

TO BE COMPLETED BY PARENT/GUARDIAN

Parent/Guardian Information All sections required – please print clearly	
Parent/Guardian Print Name:	
Parent/Guardian Home Address:	
Parent/Guardian Tel./Mobile #:	
Parent/Guardian Email Address:	
Best way to contact you:	
Child/Student Information **All sections required – please print clearly**	
Child/Student Print Name:	
Child/Student Date of Birth:	
Child/Student School:	
Child/Student Home Address:	

By signing below, I attest that:

- I consent for my child to be tested for COVID-19 infection using the University of Illinois' SHIELD Test as described in this Consent Form, including the administration of the test by Preventive Health Partners, SC or Passport Enterprises, LLC.
- I have signed this form freely and voluntarily, and I am legally authorized to make decisions for the child named above. I knowingly and voluntarily assume and accept all risks associated with my child's participation in the SHIELD Test. I understand that these risks include potential injury, illness, allergic reaction, and other potential risks of which I may not presently be aware. I also acknowledge that the results of a SHIELD Test may not be sufficient to detect or rule out the possibility that my child has been exposed to or is infected with COVID-19 and that there is a potential for a false positive or false negative test result. SHIELD Tests do not replace treatment by my child's medical provider and I assume complete and full responsibility to take action with regard to my child's test results.
- In consideration of my child's participation in the SHIELD Test at no cost, I (Parent/Guardian) on behalf of myself, my student, and my agents, representatives, assigns, heirs, and successors, hereby waive, release, indemnify, hold harmless, and covenant not to sue the School District and its Board of Education, individual Board members, employees, agents, representatives, volunteers, insurers, and assigns, and each and every one of them, from and against any and all claims, suits, liabilities, and causes of action, whether known or unknown, past, present, or future, including but not limited to any and all costs, expenses, attorneys' fees, by reason of injury, illness, allergic reaction, property damage, loss, or death, arising out of, in connection with, or in any manner related to my child's participation in the SHIELD Test, including any false test results and any resulting medical advice, course of treatment, or diagnoses or related to the sharing of my student's test results or identifying information.
- I understand that my child may be tested multiple times through June 30, 2022, and testing will occur at least 1 time per week.
- I understand that this consent form will be valid through June 30, 2022, unless I notify the designated contact person from my child's school in writing that I revoke my consent. Designated contacts are the school nurse and principals.
- I understand that my child's test results and other information may be disclosed as permitted by law, guidance, and as described above.
- I understand that if I am a student age 18 or older, or may otherwise legally consent to my own health care, reference to "my child" or "my student" refer to me and I may sign this form on my own behalf.

Signature of Parent/Guardian:		Date: