BOLTON
CENTRAL SCHOOL

26 HORICON AVENUE
BOLTON LANDING, N.Y. 12814

REQUEST FOR STUDENT COVID-19 RAPID TESTING

In preparation for testing protocols, The Bolton Central School District (the "District") is seeking your consent to test your child for COVID-19 infection. If you consent, your child will receive a weekly free diagnostic test for the COVID-19 virus that will be administered by a certified or licensed medical provider (RN). A rapid COVID-19 test will be used, which will involve inserting a small swab, similar to a Q-Tip, inside the cheek or front of the nose. We will notify you if your child tests positive for COVID-19. Any students who test positive will be sent home and must be kept at home until meeting Warren County Public Health criteria to return to school. Please contact your child's doctor immediately to review the test results should your child test positive for COVID-19.

Please complete the information below:

Student Name: _____ Date of Birth: _____

It is possible that some information about your child can be shared with Warren County and New York State Public Health Agencies. This includes notifying Warren County Public Health about the COVID-19 results of each student who is tested, including the student's name, date of birth, race, ethnicity, gender, address, phone number, and result of the COVID-19 test.

By signing below, I attest that:
1. I have signed this form freely and voluntarily, and I am legally authorized to make decisions for the child named above.
2. I authorize the Bolton Central School District to test my child for COVID-19 infection.
3. I understand that my child may be tested multiple times during the 2020-2021 school year.
4. I understand that this consent form will be valid through June 24, 2022, unless I revoke such consent in writing.
5. I authorize my child's test results and other information to be disclosed to any governmental entity as may be required or permitted by law.
6. I acknowledge that a positive test result will require my child to be sent home from school and remain at home until he/she meets the criteria to return to school according to Warren County Public Health.
7. I understand that this testing does not replace treatment by my child's medical provider, and I assume complete and full responsibility to take appropriate action regarding my child's test results. I agree that I will seek medical advice, care, and treatment for my child from his/her medical provider if I have questions or concerns or if I become ill or my condition worsens.
8. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

_____ I consent _____ I do NOT consent

_____ _____ _____
Parent Name (Print) Parent Signature Date