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

Dear Parents/Guardians:

While at school, your child can 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):___________________________________
Phone:_______________Email:____________________________________

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

a. ______ I authorize the nurse/health office staff or other trained administrative staff within Andrean High School to administer the COVID-19 BinaxNOW antigen test to my child.
b. ______ I understand that positive test results must be reported to the Lake County Department of Public Health and both positive and negative results must be reported to the Indiana Department of Health Services.
c. ______ I understand that there is the potential for a false positive or false negative COVID-19 test result.
d. ______ I acknowledge that a positive test result is an indication that my child must self-isolate and also continue wearing a mask or face covering as directed in an effort to avoid infecting others.
e. ______ I understand that the school system is not acting as my child's medical provider, this test does not replace treatment by my child's medical provider, and I assume complete and full responsibility to take appropriate action with regards to my child's test results. I

agree I will seek medical advice, care, and treatment from my child's medical provider if I have questions or concerns, or if their condition worsens.
f. ______ 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 Andrean High School 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 Andrean High School, its insurers, the Diocese of Gary, 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 Andrean'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 Andrean'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 ANDREAN HIGH SCHOOL PERSONNEL TO BE PROVIDED TO MY CHILD

Parent/Guardian Name (Printed)________________________

Parent/Guardian Signature______________________________________Date_______

This Consent Form must be completed and on file, in the school health office for your child to receive antigen testing while at school. This Consent Form is only valid during the 2021-2022 school year.