

Consent Form COVID-19 Testing

To maintain the health and safety of its students and employees in connection with the COVID-19 public health emergency, the Charleston County School District (“CCSD”) is partnering with the MUSC Health (“MUSC”) to provide COVID-19 virus testing to students and staff.

This Consent Form authorizes you/your student to be tested for the virus that causes COVID-19 according to the testing procedures outlined below.

Who may be tested?

Students/Staff will be tested if she/he has signs or symptoms consistent with COVID-19 or has had contact with or suspected exposure to person infected with COVID-19. Prior to any test of a minor student, the student parent/guardian will be consulted.

How is the test conducted?

CCSD nursing staff will collect saliva samples for testing. The sample will then be submitted to MUSC, which will test the sample for the presence of the virus. MUSC will share the results with CCSD as quickly as possible, sometimes in as little as 12 hours. CCSD will inform the person of her/his test results as soon as possible after it receives the results.

By signing this Consent Form, I agree to the following:

- a) I authorize CCSD to collect a saliva sample from me/my student and provide it to MUSC for Covid-19 testing.
- b) I consent to the collection of my/my student’s personally identifiable information and medical information, as necessary, including without limitation, my COVID-19 test result (referred to as my “Information”). I consent to CCSD’s release and disclosure of my Information to MUSC through MUSC’s chosen data collection platform.
- c) I authorize my/my student’s test results to be disclosed to CCSD by MUSC, as well as to any county, state, or other governmental entity as may be allowed and/or required by law. I understand that CCSD will maintain a record containing my Information and I consent to such record storage.
- d) I acknowledge that a positive test result requires me/my student to self-isolate and not come to school for the applicable period of time following a positive test.
- e) I understand that 1) neither CCSD or MUSC are acting as my/my student’s medical provider; 2) this testing does not replace treatment by my/my student’s medical provider; and 3) I assume complete and full responsibility to take appropriate action when I receive my/my student’s test results. I agree I will seek medical advice, care and treatment from my/my student’s medical provider if I have questions or concerns, or my/my student’s condition worsens.
- f) I understand that, as with any laboratory test, there is the potential for a false positive or false negative COVID-19 test result.
- g) I understand that there is no up-front cost for this test, but my insurance, if any, will be billed for the collection and testing of the sample.

I hereby release CCSD from any and all claims under any applicable local, state, or federal law relating to COVID-19 testing and disclosure of my/my student’s COVID-19 test results and/or related medical information by MUSC and CCSD.

Student’s name

DOB

School

Print name of Parent /Guardian or Student (if 18 years old)

Signature

Date