Elk Valley Schools

701 S Delaware, Longton, KS 67352
(620) 642-2215 / (620) 642-6551 FAX

2021-2022 School Year

Consent for Rapid CLIA COVID 19, Flu A/B, and Strep Testing

Please complete sections A, B, and C

Section A:

Student First Name:_____ Last Name:_____DOB:_____
Home Address:_____City:_____State:_____Zip:_____
Parent/guardian name:_____Phone:_____
Primary Care Physician (if known):_____Physician Phone:_____

Section B:

Please initial next to test(s) you consent for the above named individual to receive at school. You will be notified prior to any test being administered.

_____ I authorize a **COVID-19** testing administrator associated with the school district (school nurse) to conduct collection and testing for COVID-19 through a mid nasal collection when symptoms suggest it is needed. I also authorize my test results, or the test results of my child if my child is under the age of 18 years, to be disclosed to the county, state, or to any other governmental entity as may be required by law.

_____ I authorize a **rapid strep** test to be given by a testing administrator associated with the school district (school nurse) when symptoms suggest the test is needed.

_____ I authorize a **Flu A/B test** to be given by a testing administrator associated with the school district (school nurse) when symptoms suggest the test is needed.

Section C:

I certify that I am the parent or guardian of a student receiving a CLIA waived COVID-19, rapid strep or Flu A/B test. I give my consent to the Elk Valley Schools, USD #283 health office to administer the above test(s) as needed. I understand that, as with any medical test, there is the potential for false positive or false negative COVID-19, flu, or strep test results. Positive test results should be brought to the attention of your healthcare provider and used with their professional judgement as a course of treatment.
I understand it is not possible to predict all possible side effects or complications associated with receiving these tests, and release any liability of USD #283 and its staff or employees.
I authorize USD #283 to release any medical information to my healthcare professionals, as necessary with respect to the test(s) listed above.

Signature of parent/legal guardian:_____ Date:_____

Authorized Staff signature:_____ Date:_____