Dr. Sharon Locke
Superintendent

CHESTER SCHOOL DISTRICT, SAU #82
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Sheryl Rich
Financial Manager

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Symptomatic COVID-19 Antigen Test Permission Form

Your child may be eligible to receive a rapid antigen test if he/she develops a symptom of COVID-19 at school and one of our school nurses determines that they may actually be well enough to remain at school. If you would like your child to be considered to receive the authorized rapid antigen test (currently BinaxNOW), please complete the following information:

Student Name:	**DOB:**	**Grade:**
Parent/Guardian Name(s):		
Phone:	**Mobile Phone:**	

Please place your initials in the boxes below for each statement (every line must be initialed for consent to be valid).

☐ I agree to keep my child home from school if they have any new or unexplained COVID-19 symptom.

☐ I authorize the nurse or other trained administrative staff at Chester Academy to administer the COVID-19 BinaxNOW (or other authorized) antigen test to my child.

☐ If my child has persistent symptoms, I understand that my child may still be required to leave school and/or remain at home until they have been cleared to return to school.

☐ I understand that positive test results will be treated as a positive case and disclosed to county and state health officials and designated school officials.

☐ I understand that my child needs to be picked up from school immediately if their test result is positive. I agree to contact my child's medical provider for further guidance if my child's antigen test result is positive.

☐ I understand that a negative test does not necessarily rule out COVID-19 infection. If my child continues to show symptoms, I agree to keep my child home from school, and follow up with my child's medical provider.

Waiver of Liability and Release of Claims:

I acknowledge this is a voluntary testing program and that my child's participation is not required by the Chester School District. In providing my consent for the District to administer the BinaxNow (or other authorized) 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 District, its insurers, the District's Governing Board, 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 the District's administration of the COVID-19 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 the District's administration of the COVID-19 antigen test given to my child.

BY MY SIGNATURE BELOW, I AGREE TO THE ADMINISTRATION OF THE COVID-19 ANTIGEN TEST BY DISTRICT PERSONNEL TO BE PROVIDED TO MY CHILD.

Parent/Guardian Name (Printed):	**Date:**
Parent/Guardian Signature:	