

Informed Consent for COVID-19 Diagnostic Testing (Student)

I voluntarily consent and authorize UC San Diego Health, in conjunction with San Diego Unified School District, to conduct collection, testing, and analysis for the purposes of COVID-19 diagnostic tests on the student (named below).

I acknowledge and understand that the COVID-19 diagnostic test will require the collection of an appropriate sample through an anterior nasal swab, oral swab, or other recommended collection procedures.

I assume complete and full responsibility to take appropriate action with regards to test results. Should I have questions or concerns regarding student test results or physical condition, I shall promptly seek advice and treatment from an appropriate medical provider.

I understand that there will be no charge or payment to student, parent or to health insurance for this diagnostic test. I understand that the UC San Diego Health forms ask me for a Social Security Number, but that I am not required to provide this and testing will be provided whether a Social Security Number is provided or not. **Whether or not a Social Security Number is provided will not impact a student's eligibility for enrollment or receipt of educational services. Social security numbers, or the fact that one was not provided will not be shared by the District except with UCSD and UCSD will not share this information with any other person or entity**

I understand that signing this form authorizes UC San Diego Health, in conjunction with San Diego Unified School District, to test the student named below on multiple occasions (such as weekly, every 2 weeks, every 3 weeks or less frequently), depending on availability of test and virus circumstances in our community. I consent to my student being tested without my presence through August 31, 2021.

I understand that I can cancel this Consent in writing at any time prior to the test being administered. If I notify San Diego Unified School District in writing to cancel this Consent, UC San Diego Health will no longer test my child.

I understand that there is a requirement for my child to be registered as a UC San Diego Health patient (if not already registered) and to be register with MyUCSDChart for tracking purposes.

Parents will be telephoned by UC San Diego Health for any positive result for explanation and instructions. Negative results will be available on MyUCSDChart only.

TEACHING, TRAINING AND EDUCATION

I understand that as part of its teaching mission, UCSDH teaches and trains students in health care careers and that a supervised trainee may administer the COVID-19 test to my child.

SPECIMENS AND BLOOD TESTING

I understand that a health care provider may accidentally come into contact with your child's body fluids. If this happens, I consent to testing my child for infectious diseases and I agree that the exposed person may be given the results. I understand that State regulations may require UCSDH to report some medical outcomes to a regulatory health agency.

Patient Rights and Privacy Practices

a) Notice of Privacy Practices and Patient Rights: UC San Diego Health “Notice of Privacy Practices” describes how it may use and disclose your protected health information and is available at this website: <https://health.ucsd.edu/hipaa/Pages/hipaa.aspx>

b) Disclosure to Government Authorities: I acknowledge and agree that UC San Diego Health and/or San Diego Unified School District may disclose my test results and associated information to appropriate county, state entities as is required by law.

Name of Student: _____
First Last

Student Date of Birth: _____
Month / Date / Year

School of Enrollment: _____ Grade: _____ Teacher _____

Signature of Student (age 12 and older) _____ Date: _____

Signature of Parent or Legal Guardian _____ Date: _____

Printed Name of Parent or Legal Guardian: _____

Parent or Legal Guardian Date of Birth: _____
Month / Date / Year

Parent or Legal Guardian Phone Number: _____

Parent or Legal Guardian Email Address: _____