



Sussex County Public Schools Student/Staff Information (for individuals aged 18+ or who are legally emancipated)

Last Name:		First Name:	Middle Name:	Birth Date: _ / _ / _
Address: (Not a PO Box)	Street: _____			
	City: _____	State:	Zip:	
Phone:		Email:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer not to answer
Race:	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hawaiian Native or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not Stated			Hispanic/Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

By completing and submitting this form, I confirm that I authorize the collection of specimens necessary to conduct COVID-19 testing on me during school hours or in connection with school attendance/a school activity. I understand that authorizing COVID-19 testing is optional and that I can refuse to give this authorization, in which case, I will not be tested. COVID-19 screening testing will be conducted using a pooled PCR testing method. Screening testing will be conducted by a contracted vendor or school personnel. Any needed confirmatory or "follow-up" testing will be conducted by either a contracted vendor or school personnel. Diagnostic testing (including testing of close contacts), may be conducted using BinaxNOW antigen tests proctored through a brief telehealth visit with a contracted vendor, in addition to utilizing PCR testing.

Sussex County Public Schools will maintain a copy of this consent form according to existing state and federal records retention laws and will only provide COVID-19 Testing to individuals who have a completed consent form on file.



Consent and Data Sharing (please initial):

___ I authorize the collection of specimens to conduct pooled COVID-19 tests on me as part of a COVID-19 screening testing program. I understand this test will be provided at no cost to me. I understand that aggregate pooled test results for any pool of which I am a member will be reported to designated school personnel, and may be reported to me and to the Virginia Department of Health (without identifying information).

___ If I am a member of a pool that returns a positive result, I authorize the collection of specimens to conduct individual follow-up tests on me. I understand this testing will be provided at no cost to me. I understand that my individual test result will be reported to designated school personnel and me, and will be reported to the Virginia Department of Health, in accordance with state law.

___ In the event I show symptoms of COVID-19 while at school or am identified as a close contact to a person confirmed to have COVID-19, I authorize the administration of COVID-19 testing on me. I understand this testing will be provided at no cost to me. I understand that my test result will be available to designated school personnel and me, and will be reported to the Virginia Department of Health, in accordance with state law.

Authorized Signatory:

I understand that I can change my mind and cancel this permission at any time. To cancel this permission for COVID-19 testing, I need to contact MS. Adriene Stephenson, Director of Human Resources directly at 434-246-1049.

Signature

Affiliation with school (e.g., student, staff)

Printed Name

Date