VISSTA
VIRGINIA SCHOOL SCREENING TESTING for ASSURANCE

Sussex County Public Schools / Student Information			
Last Name:	First Name:	Middle Name:	Birth Date: __/____/__
Address: (Not a PO Box)	Street:_____ City:_____ State: Zip:		
Parent phone:		Parent email:	Gender: ☐ M ☐ F ☐ Non-binary ☐ Prefer not to answer
Race:	☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Hawaiian Native or Other Pacific Islander ☐ White ☐ Not Stated		Hispanic/Latino: ☐ Yes ☐ No ☐ Unknown

By completing and submitting this form, I confirm that I am the appropriate parent / legal guardian to provide consent, and that I authorize the collection of specimens necessary to conduct COVID-19 testing on my student during school hours or in connection with school attendance/ a school activity. I understand that authorizing COVID-19 testing for my student is optional and that I can refuse to give this authorization, in which case, my student 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 students who have a completed consent form on file.

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Consent and Data Sharing (please initial):

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

___ If my student is a member of a pool that returns a positive result, I authorize the collection of specimens to conduct individual follow-up tests on my student. I understand this testing will be provided at no cost to my student or me. I understand that my student's 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 my student shows symptoms of COVID-19 while at school or is identified as a close contact to a person confirmed to have COVID-19, I authorize the administration of COVID-19 testing on my student. I understand this testing will be provided at no cost to my student or me. I understand that my student's 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 of Student, Parent/Guardian Name Relationship to Student

_____ _____

Printed Name Date