

Irvington Union Free School District

COVID-19 Surveillance Testing Consent Form

- Goal:** 5% of the District in-person populations
- Purpose:** Identify individuals who have the virus, limit its spread, and cut down on the need for school closures
- Method:** BinaxNOW SARS-CoV-2 Antigen Test (rapid, nasal swab); surveillance only, cannot be used for diagnostic or travel quarantine opt-out purposes
- Location:** Will be communicated along with individual testing appointment information

Participants will be required to leave immediately following the administration of the test.

Name of Individual Tested: _____ DOB: _____

Address: _____ Phone: _____

School Building Name: _____ Grade: _____

I give the Irvington Union Free School District permission to collect a sample to test for COVID-19.

- Negative Results: will be communicated via email only
- Positive Results: communicated by phone for contact tracing, and email follow-up to provide Isolation Protocol, Westchester County DOH COVID contact information, and referral to your medical provider
- All positive results will be reported to the Westchester County DOH.

Signature: _____ Date: _____

(Individual Tested or Parent/Guardian for Individuals tested under the age of 18 is required)

Print Name of Signee: _____