TUCSON UNIFIED
SCHOOL DISTRICT

School Health Services
102 North Plumer Street
Tucson, Arizona 85719
(520) 225-3284

STUDENTS ONLY

COVID-19 BinaxNOW Antigen Testing Consent Form

And Waiver and Release of Claims

Dear Parents/Guardians:

While at school, your child may be eligible to receive a nasal swab BinaxNOW antigen test if he/she is showing symptoms of COVID-19. Symptoms may include: cough, fever, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting or diarrhea. If you would like your child to receive the BinaxNOW antigen test if he/she is showing symptoms of COVID-19, please complete the following information:

Student Name: _____ DOB:_____ Grade: _____

Parent/Guardian Name(s): _____

School: _____

Home Phone: _____ Cell Phone: _____

(Initial each line separately. Every line must be initialed for consent to be valid):

a. _____ I authorize the nurse or other TUSD trained personnel within TUSD to administer the COVID-19 BinaxNOW antigen test to my child.
b. _____ I understand that test results may be disclosed to county and state health officials and designated school officials.
c. _____ I understand that there is the potential for a false positive or false negative COVID-19 test result.
d. _____ If my child has symptoms, I have been informed that a negative test will not necessarily rule out infection or COVID-19 and my child will still be required to follow the TUSD Regulation for symptoms consistent with COVID-19.

Waiver of Liability and Release of Claims:

In providing my consent for the District to administer the BinaxNOW 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 the 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

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administration or a false negative/false positive test result from the District's administration of the COVID-19 BinaxNOW 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 attorney's 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/positive test result from the District's administration of the COVID-19 BinaxNOW antigen test given to my child.

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

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____ Date: _____

Review the BinaxNOW Fact Sheet here: https://www.fda/gov/media/141569/download

This Consent Form must be completed and on file in the health office for your child to receive antigen testing while at school. This Consent Form is only valid during the 2023-2024 school year.

HEALTH OFFICE USE

TEST RESULTS

_____ NEGATIVE _____ POSITIVE

Date and time of test: _____

Administered by: _____