Newark Community High School

District No.18

413 CHICAGO RD., NEWARK, IL 60541
PHONE (815) 695-5164
FAX (815) 695-5752
Dr. Edward A. Boswell, Superintendent
James Still, Principal

Dear Parents and Students,

Our school district has received the appropriate approvals to begin offering rapid COVID-19 antigen tests to students and staff in our district. This test will be administered by the school nurse to staff and students who have a signed permission form (attached) and a signed doctor's order (form attached) and who is exhibiting symptoms consistent with COVID-19 infection. The test requires a nasal swab sample collected from both nostrils. To collect the sample, the swab is inserted approximately one inch into each nostril and rubbed gently over the inside of the nasal passages. The results will be available within 15 minutes after testing.

Only people who exhibit symptoms consistent with COVID-19 within the last 7 days are eligible to take this test. The test is not cleared for use in asymptomatic individuals. Every student or staff who qualifies for this test will be asked permission prior to testing. For students, parents will be contacted for permission prior to testing even with a signed permission form on file for the student. Student, parent, and the student's health care provider will be contacted the same day in writing and via the family's choice of phone, text, or email with the results of the test.

Taking this test is never required. One of the benefits of offering COVID-19 testing in the schools is that non-COVID illnesses can be rapidly identified allowing students, student's siblings, and staff to remain present in school without unnecessary isolation while waiting for health care provider visits, testing, and results.

If the individual's illness, even though not related to COVID-19, necessitates them staying out of school until well enough to return, at least relatives are not required to be absent also.

Attached are forms for you to complete (permission form), take to your child's doctor to complete (physician order form), and return to the school. In order to receive a COVID-19 test, these forms need to be in your child's health file. Please contact the school nurse or the principal if you have any questions or concerns about this.

Sincerely,

Julieta Meyer RN

Julieta Meyer, RN

K. Sapsford RN

Karen Sapsford, RN

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PARENT CONSENT FOR COVID-19 DIAGNOSTIC TESTING

Consent for COVID-19 Diagnostic Testing:

I, _____ (legal name) hereby consent to COVID-19 diagnostic testing of my child including the collection, testing, and analysis, of a sample specimens(s) by Newark Community High School District 66 (the "District"), or an appropriate representative(s) of the District. I acknowledge and understand that this testing of my child will require the collection of a sample specimen(s) which may be obtained by nasal or oral swab, saliva, or other recommended collection procedures from trained personnel. I understand that there are risks—including, but not limited to, the potential for false positive or false negative test results—and benefits—including, but not limited to, helping to maintain a safe school environment—associated with my child undergoing a diagnostic test for COVID-19. I assume full responsibility for taking appropriate action with regards to my child's test results. Should I have questions or concerns regarding my child's results, confirmation of the test results, or a worsening of my child's condition, I shall promptly seek advice and treatment from an appropriate healthcare provider.

Terms and Conditions:

a. Notice of Student Privacy Rights and Practices: All results obtained through the District's testing protocol shall be used, for COVID-19 mitigation, tracking, and other purposes which may include surveys and data collection by the Illinois State Board of Education. All such results shall be retained in a confidential manner consistent with applicable State and Federal law and regulation.

b. Attestation: I attest that I have authority to execute this form providing consent for my child to participate in this COVID-19 diagnostic testing protocol.

c. Voluntary Participation: I understand that my child's participation in this COVID-19 diagnostic testing protocol is voluntary. I understand that my child may continue to attend school if I do not consent to their participation in this testing protocol or withdraw my consent, except for any required school exclusion due to an isolation/quarantine period consistent with local public health department, IDPH or CDC guidance.

d. Disclosure of Test Results and Associated Information: I acknowledge that the District may disclose my child's COVID-19 test results and mine/my child's associated information to appropriate representatives of the District and/or appropriate Federal, State, county, or other governmental and regulatory entities as may be permitted by law. Due to the ongoing public health crisis, this may include sharing my/my child's test results and associated information with public health authorities. I understand that the District will also provide me with information on my child's test results. ***I understand that the District will notify me of my child's test results via: Phone, email, or text (circle one).***

e. Release: As consideration for this testing, I hereby, for myself, and for my heirs, executors, administrators and assigns, waive, release and forever discharge the District, its Board members individually, administrators, officers, employees, volunteers, agents and representatives from any and all manner of action and actions, cause and causes of action, suits, debts, accounts, damages, claims and demands whatsoever in law, or in equity, which I may now have or may acquire, by reason of personal injury or death or loss of or damage to personal property or any other reasons, which may be related in any way to the COVID-19 testing provided by the District which may accrue on account of my child's participation. I acknowledge and agree that I have read, understand, and agreed to the statements contained within this form. I have been informed about the purpose of the COVID-19 test being used, the procedures to be performed, the potential risks and benefits, and any associated costs. I have been provided an opportunity to ask questions before providing my consent to COVID-19 testing and I understand that I may withdraw my consent to COVID-19 testing at any time. I have read the contents of this form in its entirety and I voluntarily consent to testing for COVID-19.

f. Indemnification: I hereby agree to indemnify, defend, and hold harmless the District, its Board members individually, administrators, officers, employees, volunteers and agents from any and all claims of responsibility or liability for personal injury, property damage, or loss which may arise from or is in any way connected with the COVID-19 testing provided by the District on account of my child's participation.

g. Effect of Consent: By signing below, I am indicating that I voluntarily consent to and authorize the diagnostic testing described above for the detection of COVID-19. This consent is ongoing for the duration of the District's implementation of a diagnostic testing protocol and I acknowledge that it may be revoked at any time in writing.

The tests used by the District have been approved for diagnostic use through Emergency Use Authorization by the Food and Drug Administration ("FDA"). However, a rapid test alone may not be sufficient to detect or rule out the possibility that an individual has been exposed to or is infected with COVID-19. Individuals who receive a test should carefully monitor their own symptoms.

Parent Acknowledgement and Agreement:

Student Name: _____

Parent Signature: _____

Date: _____

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DATE SPECIFIC PHYSICIAN'S ORDER

Administration of Abbott BinaxNOW Rapid Result Antigen Test for COVID-19 Infection

Physician Name _____
Address _____
_____
Phone/Contact Info _____

Signature* _____ Date Issued _____

**Physician's signature indicates that he/she allows administration of the Abbott BinaxNOW rapid result antigen test for the following individuals and for up to 4 days from the Date Issued.*

		Date(s) of Birth
Issued to *May list all members of a single family*	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Date Specific Order

NCHS18 staff trained in accordance with CDC, IDPH, and LHD guidelines may administer the Abbott BinaxNow rapid result antigen test to the above-named individual(s). This Date Specific Order shall remain in effect for 4 calendar days from the above Date Issued.

Qualifications and Requirements

The District has obtained a CLIA Certificate of Waiver and will administer tests in compliance with all applicable rules and regulations of the FDA, CDC, IDPH, and LHD. Tests are federally provided and obtained by the District through the LHD. The District will adhere to all HIPAA, FERPA, and ADA applicable laws and regulations.
All testing is offered on a voluntary basis. Students must have on file written consent from parent/guardian.

Each positive and negative result will be sent to the IDPH reporting system within 24 hours of test administration, to the LHD, to the above-named physician, as well as to the individual tested (or parent/guardian as appropriate).

In compliance with the FDA Emergency Use Authorization, this rapid antigen test will be offered to symptomatic students and staff of NCHS18.

Provider Notification

A Healthcare Provider Report form will include test results, as well as additional information including reported symptoms, exposures, and current area metrics.
Please include preferred method of communicating test results to the healthcare provider *(e.g. email or fax #)*
_____

Is there any additional information required or requested by the Provider?
_____
_____
_____

Please contact us if you have further questions.
Newark Community High School District 18
Julieta Meyer RN jmeyer@nchs18.org and
Karen Sapsford RN ksapsford@nchs18.org 815-695-5164

"Success is achieved by cooperation in teaching and learning."