Westminster Community Charter School Consent for COVID-19 Testing

What is this form?

We are seeking your consent to test your child for COVID-19 infection. Westminster Community Charter School is partnering with our established Kaleida Health School-Based Health Center to test students for COVID-19 infection per the New York State Department of Health mandate.

How often would you test my child?

If you consent your child may be selected for testing weekly to every 4 weeks. In addition, your child may be tested throughout the school year until June 30, 2021 in accordance with Department of Health mandates such as weekly testing 20% of in person students in Yellow Zones.

What is the test?

If you consent, your child will receive a free diagnostic test for the COVID-19 virus. Collecting a specimen for testing involves inserting a small swab, similar to a Q-Tip into the front of the nose.

How will I know if my child tests positive?

If your child has a specimen collected at school, we will send information home with them to let you know. COVID-19 test results will generally be provided the same day.

What should I do when I receive my child's test results?

If your child's test results are positive, please contact your child's doctor immediately to review the test results and discuss what you should do next. You should keep your child at home. If your child's test results are negative, this means that the virus was not detected in your child's specimen. Tests **sometimes** produce incorrect negative results (called "false negatives") in people who have COVID-19. If your child tests negative but has symptoms of COVID-19, or if you have concerns about your child's exposure to COVID-19, you should call your child's doctor. If you need help finding a doctor call the Kaleida HealthSchool Based Health Center at 838-7460.

TO BE COMPLETED BY PARENT OR GUARDIAN	
Parent/Guardian Information	
Parent/Guardian Print Name:	
Parent/Guardian Address:	
Parent/Guardian	

Tel./Mobile #	
Child/Student Information	
Child/Student Print Name:	
Child/Student Date of Birth:	
Child/Student Address:	

NOTIFICATION OF INFORMATION SHARING

The law allows some information about your child to be shared with and among certain New York State agencies and their contracted service providers, including NYS Department of Health. This information will be shared only for public health purposes, which may include notifying close contacts of your child if they have been exposed to COVID-19, and taking other steps to prevent further spread of COVID-19 in your school community. Information about your child that may be shared with these agencies and service providers conducting COVID testing includes your child's name and COVID-19 test result, date of birth/age, gender, race/ethnicity, school name, teacher, classroom/cohort, enrollment and attendance history, names of other family members or guardians, address, telephone, and mobile number. Sharing information about your child will **only** be done so in accordance with applicable law protecting student privacy and security of your child's data.

CONSENT

By signing below, I attest that:

- I have signed this form freely and voluntarily, and I am legally authorized to make decisions for the child named above.
- I consent for my child to be tested for COVID-19 infection.
- I understand that my child may be tested multiple times through June 30, 2021, and that testing may occur on days scheduled by Westminster Community Charter School or Kaleida Health in accordance with state mandates, such as weekly testing in schools in Yellow Zones.
- I understand that the consent form will be valid through June 30, 2021, unless I notify the designated contact person from my child's school **in writing** that I revoke my consent.
- I understand that if I revoke my consent or refuse to sign, my child may be required to continue their education via remote learning.
- I understand that my child's test results and other information may be disclosed as permitted by law.

Signature of parent/Guardian* (if child under age 18)		Date

Kaleida Health

☐ Entered into electronic record after downtime

DOWNTIME

date time

initials

SCHOOL-BASED HEALTH CENTER ENROLLMENT PACK

Patient Name

Date of Birth Admission/Visit Date Site

Medical Record Number Financial Number

Patient ID Area

INDIVIDUAL AUTHORIZATION FOR THE USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

SPECIFIC UNDERSTANDINGS: By signing this authorization form, you authorize the use or disclosure of you protected health information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. You also have the right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

It is understood that any disclosure is bound by 42 CFR Part 2 governing the confidentiality of alcohol and drug abuse patient records and that redisclosure of alcohol and drug abuse information to a party other than one designated above is forbidden without your additional written authorization.

You have the right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

You have the right to see and copy the information described on this authorization form in accordance with hospital policies. You also have the right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the hospital has already taken action based upon your authorization. To revoke this authorization, please write to Kaleida Health Privacy Officer, 726 Exchange Street, Suite 200, Buffalo, New York 14210.

SIGNATURE: *I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.*

Signature of Patient or Personal Representative Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

THE PATIENT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.

Kaleida Health

☐ Entered into electronic record after downtime

DOWNTIME

date ______ time ______

initials ______

Patient Name ______

Date of Birth ______ Admission/Visit Date ______ Site ______

Medical Record Number ______ Financial Number ______

Patient ID Area

SCHOOL-BASED HEALTH CENTER ENROLLMENT PACK 3 of 6

INDIVIDUAL AUTHORIZATION FOR THE USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date: ______

Patient Address: ______ Phone Number: ______

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION: *DO NOT SIGN A BLANK FORM. You or your personal representative should read the descriptions below before signing this form.*

Who will disclose the information? The person(s) or class of persons authorized to disclose the information are described below.

☑ Kaleida Health School-Based Health Center

Who will use and/or receive the information? The person(s) or class of persons authorized to use and/or receive the information are described below (complete name and address).

☑ Buffalo Public School District including Westminster Community Charter School

☐ Other Practitioner(s) treating student (specify): ______

☐ ______

What information will be used or disclosed? The appropriate boxes should be checked below and the descriptions should be in enough detail so that you (or any organization that must disclose information pursuant to this organization) can understand what information may be used or disclosed.

☑ The following information:

☑ All or any portion of my child's medical record to persons or entities, ***pertinent*** to his/her health care

☐ ______

☐ The following Human Immunodeficiency virus (HIV)-related information (which is any information indicating you have had an HIV-related test, or have HIV infection, HIV-related illness or acquired immunodeficiency syndrome (AIDS), or any information which could indicate that you have potentially been exposed to HIV):

______

______

What is the purpose of the use or disclosure? The purposes for which the information will be used or disclosed are described below. The words "at the request of the individual" is a sufficient description of the purpose when a patient initiates the authorization and chooses not to provide any further explanation of the purpose.

☐ At the request of the student's parent/guardian

☑ Coordination of care and treatment for the student

☐ ______

When will this authorization expire? The date or event that will trigger the expiration of this authorization should be described below.

☑ Upon the student's eighteenth birthday or when the student is no longer enrolled in a Kaleida School-Based Health Center clinic, whichever comes first.

(continued on back ➡)