INGLEWOOD UNIFIED SCHOOL DISTRICT

INFORMED CONSENT FOR COVID-19 TESTING

Individual Tested: Last Name	First Name	Middle Initial
Date of Birth (mm/dd/yyyy)	Grade	Home Phone
Name of School	Parent/Legal Guardian Emergency Phone Number	

Please carefully read the following informed consent:

1. I, on behalf of myself or my minor son/daughter/legal dependent (the "student"), authorize Inglewood Unified School District (hereinafter "IUSD") and/or an independent laboratory acting on IUSD's behalf to conduct collection and testing for exposure to the 2019 Novel Corona Virus (COVID-19) through a mid-turbinate nasal swab, saliva sample, or other minimally or non-invasive sample collection method as ordered by an authorized medical provider.
2. I acknowledge that minimally invasive sample collection methods, such as collection through a mid-turbinate nasal swab, can result in varying levels of discomfort during sample collection.
3. I understand that IUSD's independent laboratory partners are operating, as permitted under applicable laws and regulations, at various stages of the U.S. Food and Drug Administration's Emergency Use Authorization submission, acknowledgment, and approval process.
4. I acknowledge that, if the student receives a positive test result, I must ensure that the student abides by all applicable federal, state and/or local requirements with respect to isolation and quarantine to avoid infecting others.
5. I further acknowledge that, in the event of a positive test, IUSD and/or individuals or contractors acting on its behalf, may contact me and those who may have been exposed to the student and the student's identity may be disclosed to certain individuals to the extent necessary to protect the health and safety of those exposed.
6. I understand that by signing this document and agreeing that the student shall undergo COVID-19 testing, that I am not creating a patient relationship with IUSD. I understand that IUSD is not acting as a medical provider for the student. Testing does not replace treatment by a medical provider. I assume complete and full responsibility to take appropriate action with regards to the test results for the student. I agree I will seek medical advice, care and treatment from a medical provider for the student to the extent such medical advice, care and treatment becomes necessary.
7. I understand that, as with any medical test, there is the potential for false positive or false negative test results to occur.
8. I understand that IUSD has engaged certain third-party contractors and consultants to assist it in administering its COVID-19 testing program. I further understand that in order for the COVID-19 testing program to be successfully administered, certain personal information regarding the student will need to be communicated to such contractors and consultants for purposes of administering the program, and only to the extent necessary to

the administration of the COVID-19 testing program. This includes certain information contained within IUSD's My Integrated Student Information System (MiSiS), and may include personally identifiable information protected under the Family Educational Rights and Privacy Act, including student name, school, grade level, and cohort. I hereby expressly authorize such information regarding the student to be disclosed as described herein to the extent necessary to the administration of the COVID-19 testing program.

9. I understand that neither I nor my family will be charged directly for services. Third-party payment sources may be billed.
10. By signing this form, I acknowledge that I have received a copy of IUSD's Notice of Privacy Practices.

Medical records will be kept in a confidential manner; however, I acknowledge that IUSD may release information regarding treatment to third party payors such as Medi-Cal or insurance companies for the purpose of billing. I also understand that public information such as immunization history and/or communicable disease may be shared with the school nurse to protect the health of other students. I understand information may also be disclosed to certified third parties to facilitate the transmission of electronic health records.

ACCEPTANCE

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, I have been given the opportunity to ask questions before I consent, and I have been told that I can ask other questions at any time. I, on behalf of the student, voluntarily agree to testing for COVID-19.

Signature	Relationship to student	Date (mm/dd/yyyy)
Address	Telephone	
Signature verified by (**OFFICE USE ONLY**)	Date (mm/dd/yyyy)	

GenStar Labs
Thinking about you

Ed. 040121

INGLEWOOD UNIFIED SCHOOL DISTRICT

STUDENT HEALTH AND HUMAN SERVICES
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you or your child may be used and released and how you can get access to this information. Please review this document carefully.

The Inglewood Unified School District (IUSD) and its contract agencies/schools are required by federal law, the Health Insurance Portability and Accountability Act (HIPAA), to make sure that your Protected Health Information (PHI) is kept private. PHI includes information that we have created or received about you or your child's past, present, or future health/medical conditions that could be used to identify you or your child. Unless you give us written authorization, we will only release your health/medical information for treatment, payment, or health care operations or when we are otherwise required or permitted by law to do so. Not every use is listed,

but the ways we can use, and release information fall within one of the descriptions below.

1. **Appointment reminders and health-related benefits or services**: We may use PHI to send you appointment reminders. We may also use PHI to give you information about other health care related treatment and services.
2. **Treatment**: We may use and release your PHI to those who provide you with health care services or who are involved with you or your child's care such as doctors, nurses and other health care professionals. PHI may also be used for referrals to hospitals, specialists, or for other treatment alternatives. For example, we may share the PHI with relevant school staff for Individualized Educational Program (IEP) purposes to recommend appropriate Special Education related services to address your child's health
needs while at school.
3. **To receive payment for the treatment that was provided to you or your child**: We may use and release your PHI in order to bill and receive payment for treatment and services you or your child received in the school or community setting. For example, IUSD bills Medicaid for services that are provided to Medi- Cal eligible students.
4. **Health Care Operations**: We may use and release your PHI in order to administer our school-based health centers. For example, members of our quality improvement team may use information in you or your child's health record to review the care and outcomes for quality improvement purposes.
5. **To meet legal requirements**: We may use and release PHI to government officials or law enforcement agencies when federal, state, or local laws require us to do so. We also share PHI when we are required to do so in a court or other legal proceedings. For example, if a law says we must report private information about students, who have been abused, we will provide such information.
6. **To report Public Health activities**: We may use and release PHI to government officials in charge of collecting certain public health information. For example, we share general information about immunizations, deaths, and some statistical information about diseases such as pertussis or chickenpox.
7. **For Research purposes**: We do not release PHI for purposes of medical research. We do, however, use PHI to create a collection of information that cannot be traced back to you or your child.
8. **To avoid harm**: In order to avoid a serious threat to the health and safety of a person or the public, we may provide PHI to law enforcement, emergency personnel, or others who may be able to stop or lessen the harm.
9. **Fundraising**: We may use and release the PHI toward applying for grants and/or funding agencies to obtain funds for the enhancement and expansion of our services. (Although allowable by law, it is not IUSD practice to use or release your PHI in a manner that can be traced back to you or your child.)

Your Rights

- See or obtain a copy of information that we have about you or your child or correct you or your child's personal information that you believe is missing or incorrect. If someone else (such as your doctor) gave us the information, we will tell you who, so that you can ask them to correct it.
- Ask us not to use your health information for payment or health care operations activities. (We are not required to agree to these requests.)
- Ask us to communicate with you about health matters using reasonable alternative means or at a different address, if communications to your home address could endanger you.
- You have a right to withdraw or revoke your consent in writing at any time. However, we may refuse to continue to treat a child if the parent revokes his or

her consent.

- Receive a list of disclosures of your health information that we make on or after August 25th, 2021, except when:
  - You have authorized the disclosure;
  - The disclosure is made for treatment, payment or health care operations; or
  - The law otherwise restricts the accounting.

Complaint Process

If you believe that we may have violated your Privacy rights, you may send your written complaint to: Inglewood Unified School District Student Health and Human Services 401 South Inglewood Avenue, Inglewood, CA 90301

Alternative method of processing a complaint:
Privacy Complaints
U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services

INGLEWOOD UNIFIED SCHOOL DISTRICT
AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

This Authorization describes how we may use and disclose your information to facilitate the Inglewood Unified School District's ("IUSD") COVID-19 testing and school community engagement program.

Completion of this document authorizes the disclosure and use of health information about you. Please provide all the information requested or this authorization may not be valid.

Authorization Required for Testing. I hereby authorize IUSD to use and disclose the following information about the individual identified below (referred to as "I," "me," or "my" in this Authorization):

> All information that identifies me or that relates to testing me for exposure to the 2019 Novel Corona Virus (COVID-19) that is collected or created as a part of IUSD's testing and school community engagement program, including without limitation my COVID-19 test results.

I authorize IUSD to use and disclose the above information for any purpose related to IUSD's COVID-19 testing and school community engagement program, including uses and disclosures required by law, disclosures to any county, state, or other government public health or other agency with jurisdiction, disclosures to IUSD's contractors, vendors, and medical research partners for purposes of assisting in the design, development and operation of the testing program.

I further authorize IUSD to disclose the above information for purposes of public health research for which individual information will not be published, for purposes of obtaining payment or reimbursement for testing and related services, or for purposes of notifying parents, teachers or other staff, or members of the public about school and community exposure and infection rates, which may include without limitation publication on IUSD's website or through the news or other media, and which may be done in a manner which will not include my name, but from which my identity could potentially be determined.

Expiration. This Authorization will expire after a period of one (1) year.
I Understand My Rights. I understand that:

I may refuse to sign this Authorization;

Refusal to sign this authorization will not result in IUSD's denial of any treatment for any health care condition or payment for health care that would otherwise be provided, or in IUSD's denial of any otherwise existing eligibility or enrollment in any health benefit program;

I have the right to receive a copy of this Authorization;

I may revoke this authorization at any time, but I must do so in writing and send it to:

Inglewood Unified School District
401 South Inglewood Avenue
Inglewood, CA 90301

Re-Disclosure. I understand that information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by applicable law and may no longer be protected by federal confidentiality laws such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please print the Name of Individual for Whom This Authorization is Given (*e.g.*, name of student, employee or other person to be tested):

___Student___Employee___Other (Please describe):

Signature of adult to be tested or parent/guardian of minor for whom authorization is being provided:

Date:

If signed by other than the patient, indicate relationship and print name:

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