**Abbott BinaxNOW Antigen Test for Symptomatic Individuals**

**Parent/Guardian Authorization for Student**

By completing and submitting this form, I confirm that I am the appropriate parent / guardian to provide consent, and that I authorize the administration of a COVID-19 antigen test on my student during school hours, should school staff observe symptoms consistent with COVID-19 or isolated symptoms (e.g., isolated runny nose, isolated headache, or isolated abdominal pain without fever). I understand that authorizing a COVID-19 test for my student is optional and that I can refuse to give this authorization, in which case, my student will not be tested. I further understand that my student **must** stay home if feeling unwell.

**Student Demographic Information:**

Student’s First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s address (street, city, zip code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the student’s date of birth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the student’s race? (Select all that apply):

\_\_\_\_ American Indian/Alaskan Native

\_\_\_\_ Asian

\_\_\_\_ Black/African American

\_\_\_\_ Native Hawaiian/Pacific Islander

\_\_\_\_ White

\_\_\_\_ Other

\_\_\_\_ Unknown

Is the student of Hispanic origin? (Select one):

\_\_\_\_ Yes

\_\_\_\_ No

\_\_\_\_ Unknown

What is the student’s gender? (Select one):

\_\_\_\_ Male

\_\_\_\_ Female

\_\_\_\_ Transgender

\_\_\_\_ Unknown

Does the student have a disability? (Select one):

\_\_\_\_ Yes

\_\_\_\_ No

What is the student’s primary language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Information:**

Parent/Guardian First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Address (if different than above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent and Data Sharing (please initial):**

\_\_\_\_\_ In the event my student shows symptoms of COVID-19, I authorize an administration professional, during school hours, to administer the Abbott BinaxNOW COVID-19 antigen test on my student. I understand that my student’s test results will be loaded to Project Beacon, which will share them with the Massachusetts Department of Public Health in accordance with state law.

\_\_\_\_\_ I authorize the disclosure of my contact information to Project Beacon (a third-party organization contracted to compile consent for testing and to share test results). I understand that along with test results, Project Beacon will share my contact information with DPH. I also understand that I can create a user profile in Project Beacon that will notify me about test administration and test results. I agree that if I create such a user profile, I will only use the Project Beacon system for the purpose of accessing information, including test results, that I am legally allowed to access.

**Authorized Signatory:**

I understand that I can change my mind and cancel this permission at any time, but that such cancellation is forward-looking only, and will not affect information I already permitted to be released. To cancel this permission for COVID-19 testing, I need to contact Project Beacon directly at (617) 741-7310.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name (Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Parent/Guardian Signature Date

**Abbott BinaxNOW Antigen Test for Symptomatic Individuals**

**authorization for student/staff who can authorize for themselves**

By completing and submitting this form, I authorize the administration of a COVID-19 antigen test on me during school hours if I develop symptoms consistent with COVID-19 or minimal symptoms (e.g., isolated runny nose or, headache, or abdominal pain without fever). I understand that such testing is optional, and I can refuse to give this authorization, in which case, I will not be tested. I further understand that I **must** stay home if feeling unwell.

**Demographic Information:**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (street, city, zip code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your date of birth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your race? (Select all that apply):

\_\_\_\_ American Indian/Alaskan Native

\_\_\_\_ Asian

\_\_\_\_ Black/African American

\_\_\_\_ Native Hawaiian/Pacific Islander

\_\_\_\_ White

\_\_\_\_ Other

\_\_\_\_ Unknown

Are you of Hispanic origin? (Select one):

\_\_\_\_ Yes

\_\_\_\_ No

\_\_\_\_ Unknown

What is your gender? (Select one):

\_\_\_\_ Male

\_\_\_\_ Female

\_\_\_\_ Transgender

\_\_\_\_ Unknown

Do you have a disability? (Select one):

\_\_\_\_ Yes

\_\_\_\_ No

What is your primary language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent and Data Sharing (please initial):**

\_\_\_\_\_ In the event I show symptoms of COVID-19, I authorize an administration professional, during school hours, to administer the Abbott BinaxNOW COVID-19 antigen test on me. I understand that my test results will be loaded to Project Beacon, which will share them with the Massachusetts Department of Public Health in accordance with state law.

\_\_\_\_\_ I authorize the disclosure of my contact information to Project Beacon (a third-party organization contracted to compile consent for testing and to share test results). I understand that along with test results, Project Beacon will share my contact information with DPH. I also understand that I can create a user profile in Project Beacon that will notify me about test administration and test results I agree that if I create such a user profile, I will only use the Project Beacon system for the purpose of accessing information, including test results, that I am legally allowed to access.

I understand that I can change my mind and cancel this permission at any time, but that such cancellation is forward-looking only, and will not affect information I already permitted to be released. To cancel this permission for COVID-19 testing, I need to contact Project Beacon directly at (617) 741-7310.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature Date