VISSTA
VIRGINIA SCHOOL SCREENING TESTING for ASSURANCE

Surry County Public Schools **Student/Staff Information** (for individuals aged 18+ or who are legally emancipated)			
Last Name:	**First Name:**	**Middle Name:**	**Birth Date:** __/__/__
Address: (Not a PO Box)	**Street:**_____ **City:**_____ **State:** **Zip:**		
Phone:		**Email:**	**Gender:** ☐ M ☐ F ☐ Nonbinary ☐ Prefer not to answer
Race:	☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Hawaiian Native or Other Pacific Islander ☐ White ☐ Not Stated		**Hispanic/Latino:** ☐ Yes ☐ No ☐ Unknown

By completing and submitting this form, I confirm that I authorize the collection of specimens necessary to conduct COVID-19 testing on me during school hours or in connection with school attendance/a school activity. I understand that authorizing COVID-19 testing is optional and that I can refuse to give this authorization, in which case, I will not be tested. COVID-19 screening testing may be conducted using a pooled PCR testing method or individual PCR testing method. Screening testing will be conducted by contracted vendor or school personnel. Any needed confirmatory or "follow-up" testing will be conducted by either a contracted vendor or school personnel. Diagnostic testing (including testing of close contacts), may be conducted using BinaxNOW antigen tests proctored through a brief telehealth visit with a contracted vendor, in addition to utilizing PCR testing.

Surry County Public Schools will maintain a copy of this consent form according to existing state and federal records retention laws and will only provide COVID-19 Testing to individuals who have a completed consent form on file.

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Consent and Data Sharing (please initial):

___ I authorize the collection of specimens to conduct COVID-19 tests on me as part of a COVID-19 screening testing program. I understand this test will be provided at no cost to me. I understand that aggregate pooled test results for any pool of which I am a member will be reported to designated school personnel, and may be reported to me and to the Virginia Department of Health (without identifying information) before a final individual result is available.

____ In the event I show symptoms of COVID-19 while at school or am identified as a close contact to a person confirmed to have COVID-19, I authorize the administration of COVID-19 testing on me. I understand this testing will be provided at no cost to me. I understand that my test result will be available to designated school personnel and me, and will be reported to the Virginia Department of Health, in accordance with state law.

Authorized Signatory:

I understand that I can change my mind and cancel this permission at any time. To cancel this permission for COVID-19 testing, I need to contact the school nurse in the building that I am assigned.

_____ _____

Signature Affiliation with school (e.g., student, staff)

_____ _____

Printed Name Date