VISSTA
VIRGINIA SCHOOL SCREENING TESTING for ASSURANCE

Surry County Public Schools **Student Information**					
Last Name:		**First Name:**		**Middle Name:**	**Birth Date:** __/__/__
Address: (Not a PO Box)	**Street:**______ **City:**______ **State:** **Zip:**				
Parent phone:		**Parent 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 am the appropriate parent / legal guardian to provide consent, and that I authorize the collection of specimens necessary to conduct COVID-19 testing on my student during school hours or in connection with school attendance/ a school activity. I understand that authorizing COVID-19 testing for my student is optional and that I can refuse to give this authorization, in which case, my student 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 a contracted vendor or school personnel. Any needed confirmatory or "follow-up" testing will be conducted by either 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 students who have a completed consent form on file.

VISSTA
VIRGINIA SCHOOL SCREENING TESTING for ASSURANCE

Consent and Data Sharing (please initial):

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

___ In the event my student shows symptoms of COVID-19 while at school or is identified as a close contact to a person confirmed to have COVID-19, I authorize the administration of COVID-19 testing on my student. I understand this testing will be provided at no cost to my student or me. I understand that my student's 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.

______________________________ ______________________

Signature of Student, Parent/Guardian Name Relationship to Student

______________________________ ______________________

Printed Name Date