COVID-19 Testing Consent and HIPAA Data Use Authorization

I authorize the use of my oropharyngeal nasal /or saliva specimen for COVID-19 Testing; or if representing a minor, I as parent or legal guardian, authorize the use of my child's oropharyngeal nasal/or saliva specimen for Covid-19 Testing. I further understand, agree, certify, and authorize the following:

1. San Diego French-American School ("SDFAS" or the "School") has partnered with *UCSD EXCITE Laboratory*, a CAP/CLIA Accredited Laboratory for laboratory analysis and reporting of my specimen. I authorize this laboratory to perform testing on my or my child's specimen.
2. I understand that the processing of the specimen and results may take between 24 and 48 hours. I further understand that whilst the testing laboratories have conducted extensive validation studies there is still potential for uninformative results or incorrect results.
3. I authorize the laboratory to release test results or other information as required to the Centers for Disease Control and Prevention (CDC) and The California Reportable Disease Information Exchange (CalREDIE), and San Diego County Health and Human Services Agency.
4. I understand that the test results may provide information that could impact my child's, my own and other family members' health, including the risk of developing a particular condition.
5. I understand that the test results may lead to me, my child, and other person's with whom I have recently been in contact, being contacted by San Diego County Health and Human Services for the purposes of contact tracing.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. You have the right on behalf of you and your child to restrict how your and your child's protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

By signing this form, you consent to our use and disclosure of your child's protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

1. Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
2. If you or your child are a member of the School community (student, employee) and the test is being performed at the request of the School, then the test is intended for workplace or school campus safety screening purposes and the test results will be provided to both the School (School Designee: School Nurse and Head of School; or in

their exceptional absence, a Designee of the School) and the community member (SDFAS employee or student) who was tested, and if a student to the student's parent(s) or guardian(s).

3. Individuals with a positive test result (or their parents in the case of a student) should immediately seek advice from their or their child's Healthcare Provider and the School, as applicable.
4. The person being tested, or in case of a minor, a legal guardian, has the right to revoke this consent in writing at any time and all full disclosures will then cease.
5. The portion of your or your child's specimen left over after completion of testing may be deidentified and used for research and development.

·Are you willing to be contacted about potential research projects? YES ▢ NO ▢

·May we phone, email, or send a text to you to confirm appointments?

_____ YES ▢ NO ▢

·May we leave a message on your answering machine or on your cell phone?

_____ YES ▢ NO ▢

·May we discuss your or your child's medical condition with a member of your family?

_____ YES ▢ NO ▢

If YES, please name the member(s) allowed:

_____

By signing I acknowledge that I have read, understand, agree, certify, and/or authorize the information above and further agree to hold harmless both SDFAS and UCSD EXCITE Laboratory and their affiliate laboratories, including its employees, agents, and contractors from any and all liability and claims. This consent is signed for

Print Full Name of Person Whose Sample is Being Taken: _____

If an SDFAS Employee: Signature of Person Whose Sample is Being Taken

_____

If an SDFAS Student: Parent or Legal Guardian's Full Name & Signature:

Print name: _____

Signature: _____

Date:_____