



River Bend Community Unit School District #2

Where Everybody is Somebody

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INFORMED CONSENT & RELEASE FOR COVID-19 DIAGNOSTIC TESTING

Authorization and Consent for Covid-19 Diagnostic Testing:

I voluntarily consent and authorize River Bend CUSD #2 to conduct collection, testing, and analysis from either myself or my student/child for the purposes of a COVID-19 diagnostic test. I acknowledge and understand that the COVID-19 diagnostic test will require the collection of an appropriate sample through a nasopharyngeal swab, oral swab, or other recommended collection procedures. I understand that there are risks and benefits associated with undergoing a diagnostic test for COVID-19 and there may be a potential for false positive or false negative test results.

I assume complete and full responsibility to take appropriate action with regards to the test results. Should I have question or concerns regarding the results, or a worsening of mine or my student's condition, I shall promptly seek advice and treatment from an appropriate medical provider.

Disclosure to Government Authorities

I acknowledge and agree that River Bend CUSD #2 may disclose my test results and associated information to appropriate county, state, or other governmental and entities as may be permitted by law.

Release

To the fullest extent permitted by law, on behalf of myself and/or my student I hereby release, discharge and hold harmless, River Bend CUSD #2, including, without limitation, any its respective elected officials, employees, representatives and agents from any and all claims, liability, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to the COVID-19 diagnostic test or the disclosure of the COVID-19 test results.

Acknowledgment

I acknowledge and agree that I have read, understand, and agreed to the statements contained within this form. I have been informed about the purpose of the COVID-19 diagnostic test, procedures to be performed, potential risks and benefits, and associated costs. I have been provided an opportunity to ask questions before proceeding with a COVID-19 diagnostic test and I understand that if I do not wish to continue with the collection, testing, or analysis of a COVID-19 diagnostic test, I may decline.

Name of the individual requesting testing: _____

____ Student ____ Employee ____ Adult working in River Bend CUSD #2 buildings

Date of test: _____ Date of Birth _____

Phone: _____ Address: _____

Printed Name of Individual Being Tested: _____

Signature of Individual Being Tested or Parent/Guardian if under 18:
