LORAIN CITY SCHOOLS STUDENT CONSENT FOR COVID-19 TESTING & AUTHORIZATION/RELEASE FORM

May we leave a message?

Student Name _____ Cell Phone _____ ☐Y ☐N _____ Initial

DOB-mm/dd/yyyy _____

Address _____ City _____ State _____ Zip _____ Home Phone _____

Emergency contact:

Name_____**Relationship**_____**Phone**_____

1. **Consent for Testing:** I consent to COVID-19 virus testing for the purposes of permitting Lorain City Schools to evaluate whether I am currently infected with the COVID-19 virus.

2. **Release of Information**: I understand that Bon Secours Mercy Health (BSMH) may release medical and/or treatment information regarding my test results to Lorain City Schools. I hereby authorize the use or disclosure of my health information as described in this form, including that my results may be shared with federal/state/local governmental authorities, as permitted or required by law. This authorization shall expire one (1) year from the date of my signature below. I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to **BSMH Privacy Officer, 1701 Mercy Health Place, Cincinnati, OH 45237.** I understand that a revocation is not effective to the extent that BSMH has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself. I understand that BSMH will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and of the consequences of me refusing to sign this authorization. I understand there is the potential for information used or disclosed pursuant to this authorization to be subject to re-disclosure by the recipient if the recipient is not required by law to protect the privacy of the information. I understand that I will receive a copy of this authorization if signed by me.

3. **Financial Agreement:** Lorain City Schools will remit payment on my behalf to cover all costs associated with the COVID-19 virus testing.

4. **Certification:** These conditions have been explained to me and I certify that I understand their contents. I further certify that I consent to testing and consent to release of my COVID-19 virus test results to Lorain City Schools and federal/state/local governmental authorities, as permitted or required by law.

Student Signature _____ Date _____ Witness _____ Date _____

Signature of Person Authorized to Consent (if Student is under 18 years of age) _____ Date _____ Relationship _____

By initialing below, I authorize and consent to receive email message communications to my email address related to my current and/or prospective medical care at the following _____ (email address). Communications may include email messages related to my current and/or prospective medical care as provided by Bon Secours Mercy Health or its affiliates. Additionally, by initialing below, I authorize and consent to email communications related to laboratory outcomes of my COVID-19 test results.
Communications may come from Bon Secours Mercy Health or its affiliates and/or clinical providers. Standard message and data rates may apply. I may revoke this consent at any time and my consent is not required to receive medical care.

I consent [initials:_____] I do not consent [initials:_____]

Ohio | Department of Health

COVID-19 Questionnaire

(circle your answer)

COVID-19 has disproportionately impacted people of different ethnicities and age. In an effort to learn more about the virus, state law and CDC research and disease tracking guidelines require us to include the following questions using these specific categories.

1. **Is this your first COVID-19 test?** Yes No Unknown

2. **Are you employed in healthcare?** Yes No Unknown

3. **Are you symptomatic as defined by the CDC?** Yes No Unknown

   If yes, Date of Symptom onset: __ _ / __ _ /_ _ (mm/dd/yy)

4. **Have you recently been hospitalized?** Yes No Unknown

5. **Have you recently been in an ICU?** Yes No Unknown

6. **Have you been a resident in a congregate care setting?** Yes No Unknown
   (Including nursing homes, residential care for people with Intellectual and developmental disabilities, psychiatric treatment facilities group homes, board and care homes, homeless shelter, foster care or other setting)

7. **Are you pregnant?** Yes No Unknown

8. **What is your gender?** Male Female Other

What is your ethnicity/race?

____American Indian or Alaska Native
____Asian
____Black or African American
____Hispanic or Latino
____Native Hawaiian and Pacific Islander
____White
____Other