

Date: December 14, 2020

Dear Parents, Caregivers, and Guardians,

Thank you for your continued partnership during this unprecedented school year. In an effort to prevent the spread of COVID-19, we have been working closely with the Massachusetts Department of Elementary and Secondary Education (DESE) and the Massachusetts Department of Public Health (DPH) to offer **free rapid COVID-19 testing for symptomatic staff and students participating in any type of in-person instruction.**

The purpose of this letter is to ask your permission to test your child should he or she develop symptoms at school. While we have asked all students and staff who are sick to stay home, there may be members of our school community who first present symptoms while in school. Being able to test your child at school will not only expedite results and therefore help you determine next steps to protect your student and your family, but also provide some peace of mind that a test is available and can be delivered by a nurse if the need arises.

The COVID-19 Rapid Antigen COVID-19 Diagnostic Test is FDA approved and delivers results in 15 minutes. Our school nursing staff has been thoroughly trained on how to administer the test using a nasal swab. The decision to administer the test will be made by the school nurse, and you will be notified via phone call before your child is tested.

You will also be notified immediately of the test results. If a student tests positive, the student will be sent home and must quarantine for at least 10 days and until at least 24 hours have passed with improvements in symptoms and no fever, without the use of fever reducing medications. If a student tests negative, they may also be sent home. Regardless of the test result, you will be notified by the school regarding next steps to take with a healthcare provider. Webster Public Schools will report all test results to DPH and positive test results to DESE's Rapid Response Help Unit.

To give permission for your student to participate in the COVID-19 Rapid Antigen Diagnostic Test, including permitting the school to share the test result information with the Department of Public Health and Project Beacon (a third party non-profit organization contracted to compile consent for testing and to share test results), please fill out the permission slip attached to this letter. Please return this form to your school nurse as soon as possible.

At Webster Public Schools, we are extremely grateful to our committed staff and families that continue to show great flexibility and resilience as we navigate through this school year. It takes all of us working together to contain the spread of this virus.

If you have questions regarding the COVID-19 Rapid Antigen Diagnostic Test, please reach out to your school nurse.

Thank you,

Dr Ruthann Goguen

Webster Public Schools
Bartlett High School - Webster Middle School - Park Ave Elementary School

Abbott BinaxNOW Antigen Test - Parent/Guardian Authorization for Student to be tested

By completing and submitting this form, I confirm that I am the appropriate parent / guardian to provide consent, and that I authorize the administration of a COVID-19 antigen test on my student during school hours, should school staff observe symptoms consistent with COVID-19 or isolated symptoms (e.g., isolated runny nose, isolated headache, or isolated abdominal pain without fever). I understand that authorizing a COVID-19 test for my student is optional and that I can refuse to give this authorization, in which case, my student will not be tested. I further understand that my student **must** stay home if feeling unwell.

Student Demographic Information: please print clearly!

Student's First Name:	
Student's Last Name:	
Student's Middle Name:	
Student's address (street, city, zip code)	
What is student's Date of Birth?	
What is the student's race? (select all that apply)	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Is the student of Hispanic origin? (select one)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
What is the student's gender? (select one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown
Does the student have a disability? (select one)	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is the student's primary language?	

please continue to fill out the back of this form ➡

Parent/Guardian Information: please print clearly!

Parent/Guardian First Name:	
Parent/Guardian Last Name:	
Parent/Guardian Address (if different than above):	
Parent/Guardian Phone Number:	
Parent/Guardian Email Address:	

Consent and Data Sharing (please initial):

_____ In the event my student shows symptoms of COVID-19, I authorize an administration professional, during school hours, to administer the Abbott BinaxNOW COVID-19 antigen test on my student. I understand that my student's test results will be loaded to Project Beacon, which will share them with the Massachusetts Department of Public Health in accordance with state law.

_____ I authorize the disclosure of my contact information to Project Beacon (a third party organization contracted to compile consent for testing and to share test results). I understand that along with test results Project Beacon will share my contact information with DPH. I also understand that I can create a user profile in Project Beacon that will notify me about test administration and test results. I agree that if I create such a user profile, I will only use the Project Beacon system for the purpose of accessing information, including test results, that I am legally allowed to access.

Authorized Signatory:

I understand that I can change my mind and cancel this permission at any time, but that such cancellation is forward-looking only, and will not affect information I already permitted to be released. To cancel this permission for COVID-19 testing, I need to contact Project Beacon directly at (617) 741-7310.

Parent/Guardian Name (Print)

Parent/Guardian Signature

Date

Please return this signed form to your school nurse as soon as possible!