



# Charter School for Applied Technologies

www.csat-k12.org

## Consent for COVID-19 Testing at School

The Charter School for Applied Technologies (CSAT) is seeking your consent to test your child for COVID-19. If you consent, your child may receive a free diagnostic test for the COVID-19 virus. The test will be administered by a trained nurse from CSAT or a partner agency.

Collecting a specimen for testing involves inserting a small swab (similar to a Q-tip) into the front of the nose.

We will notify you and the Erie County Department of Health (ECDOH) if your child tests positive for COVID-19. Any student who tests positive will be sent home and must follow the ECDOH criteria to return to school. You must contact your child's healthcare provider immediately to review the results and obtain instructions for care if your child test positive for COVID-19.

New York State law requires some information about your child to be shared with the local and state health departments, including the COVID test results, the student's name, date of birth, race, ethnicity, gender, address, and phone number.

### **Student Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Grade: \_\_\_\_\_

### **Consent:**

By signing below, I attest that:

- I have signed this form freely and voluntarily, and I am legally authorized to make decisions for the child named above.
- **I consent for my child to be tested for COVID-19.**
- I understand that my child may test multiple times during the 2020-2021 school year.
- I understand that this consent is valid through June 30, 2021, unless I revoke the consent in writing.
- I authorize my child's test results and other information to be disclosed as permitted by law.
- I acknowledge that a positive COVID-19 test will require my child to be sent home and follow the ECDOH criteria before returning to school.
- I understand that this testing does not replace treatment by my child's healthcare provider.
- I assume full responsibility to take appropriate action by seeking medical advice, care, and treatment for my child.
- I understand that there is the potential for a false positive or a false negative test result.

Parent name: \_\_\_\_\_

Parent signature: \_\_\_\_\_

Date: \_\_\_\_\_ Parent contact Number: \_\_\_\_\_

#### Elementary School // K-5

2303 Kenmore Avenue  
Buffalo, New York 14207  
(716) 876-7505

#### Middle School // 6-8

24 Shoshone Street  
Buffalo, New York 14214  
(716) 710-3065

#### High School // 9-12

2245 Kenmore Avenue  
Buffalo, New York 14207  
(716) 871-7400

#### Family Support Center

317 Vulcan Street  
Buffalo, New York 14207  
(716) 871-7400