



SUMMIT ACADEMY  
150 Stahl Road, Getzville, New York 14068 • (716) 629-3400 • FAX (716) 629-3497

### COVID-19 SCHOOL TESTING CONSENT

Summit Academy is presently designated as part of a micro-cluster during the COVID-19 pandemic. Summit is now mandated to test a percentage of students (between 20 and 100% depending on the cluster designation) who receive in-person instruction at one of our buildings. Please review this entire document, select one of the 3 options and sign below.

\_\_\_\_\_ **Option 1: I consent to allow Summit's school nurse, or other trained staff, to administer a COVID test to my child.** I understand that this test may be administered at school during when I will not be present. I understand that all testing data will be shared with the Department of Health. I understand that I will receive the results of this test from either a school employee or the local Department of Health. I understand that this test is minimally invasive and not painful, but my child may find it to be unpleasant. I understand that the test administration may not be successful, and staff will cease administration efforts if my child actively resists the test or demonstrates maladaptive behaviors. I understand that if the school testing attempt is unsuccessful, my child **may** need to move to remote instruction (depending on the cluster designation) until I can produce results of a negative test administered elsewhere. I understand that I will need to follow all isolation and contact tracing requirements from the Department of Health if my child tests positive.

\_\_\_\_\_ **Option 2: I do not want my child's test administered at Summit and instead will have my child tested for COVID-19 by an outside source within 4 days of Summit's request.** I understand I will need to provide proof of testing and documentation of results to Summit. I understand that my child **may** need to move to remote instruction (depending on the cluster designation) if I fail to have my child tested. I understand that I will need to follow all isolation and contact tracing requirements from the Department of Health if my child tests positive.

\_\_\_\_\_ **Option 3: I do not provide consent for my child to receive COVID testing at school and do not plan to have my child tested elsewhere.** I understand that my child **may** return to virtual-only learning (depending on the cluster designation).

Please select one of the options above and complete the information below. You may change your option at any time by completing a new form. This consent will remain in effect during the entire pandemic period unless specifically modified or revoked in writing.

**Please print:**

Child Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Classroom #: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Phone number: \_\_\_\_\_

**Please sign:**

\_\_\_\_\_

Date: \_\_\_\_\_