



COVID-19 Symptomatic Testing Informed Consent Form

This consent provides Philadelphia Hebrew Public with your permission to perform a COVID-19 screening test based on the need to maintain a safe environment for students and staff members, and other essential persons with whom you may come into contact. By signing below, you are indicating that you voluntarily consent to be tested for COVID-19. You agree that Philadelphia Hebrew Public may test if your student becomes symptomatic. The costs of these screening tests are covered by Philadelphia Hebrew Public, and neither you nor your insurance will be billed for any costs associated with this test.

The COVID-19 test(s) being administered involves collecting a shallow nasal swab specimen that will be tested to indicate the potential presence of COVID-19. For additional information, you may contact nurse@philadelphiahebrewpublic.org.

If you are ineligible to enter our facilities due to a positive test, it is recommended that you consult with your physician for advice and treatment and notify the school nurse at nurse@philadelphiahebrewpublic.org.

If you decline the test or your test results are positive, you will be denied entry to the facility or be asked to leave the facility. If you are a Philadelphia Hebrew employee, you may contact administration about sick leave and related issues at akellman@philadelphiahebrewpublic.org.

The COVID-19 test(s) have been authorized by the United States Food and Drug Administration; however, the test alone may not be sufficient to detect or rule out the possibility that you have been exposed to or are infected with COVID-19. There is the potential for a false positive or false negative test result to occur. *You should carefully monitor your symptoms, and regardless of the results of any testing, stay home and consult with your physician or another medical professional if you experience symptoms associated with COVID-19.*

Statement of Consent

I have read and understand this form, and its contents were explained to me. My questions have been answered. By signing below, I consent to administration of the COVID-19 test and agree to waive any claim against Philadelphia Hebrew Public and/or its medical providers and staff members arising from my agreement to receive this voluntary testing, and for any risks, side effects, or complications resulting from the testing. If requested, Philadelphia will provide a signed and dated copy of this form for my records.

First and Last Name of Parent and Student Printed

Parent/Guardian Signature

Date

Cell Phone Number

Authorization to Use and Disclose Health Information

I hereby authorize the Philadelphia Hebrew Public Charter School to disclose my COVID-19 test results to Philadelphia Hebrew Public School's nurse and administrative staff to determine if I may enter the Philadelphia Hebrew Public Charter School Building.

I understand that if I do not sign this authorization, I will not be tested for COVID-19.

This authorization will expire five years from the date of my signature below.

I may revoke this authorization at any time by sending written notice to Philadelphia Hebrew School. If I revoke my authorization, my test results will not be shared with PHP staff from that date forward.

I understand that after my COVID-19 test results are disclosed, they may no longer be protected by the Health Insurance Portability and Accountability Act; however, they will continue to be protected by the Confidentiality of Medical Information Act.

If requested, PHP will provide a signed and dated copy of this form for my records.

I agree that PHP's determination of whether I am clear to enter PHP facilities may be texted to my cell phone number/emailed.

First and Last Name of Parent and Student Printed

Parent/Guardian Signature

Date

Cell Phone Number