

Increasing Community Access to **Testing (ICATT)**  
**ICATT Voluntary COVID-19 Testing**  
**Staff or Adult Consent Form**

School testing will maximize the longevity of in-person learning by quickly detecting, tracing, and isolating COVID-19 positive individuals — whether or not they become symptomatic. And, it will provide families and staff with peace of mind. The current safety measures in place, combined with testing for staff and students, will lower the risk of transmission and allow more consistent access to in-person instruction for our students.

**What is the test?**

The testing is an anterior-nasal swab test (a short swab no longer than a typical Q-Tip) and takes only a few seconds to collect. This is a non-invasive collection method.

**Will this information be shared?**

This information will be shared only for public health purposes, which may include notifying close contacts if you have been exposed to COVID-19, and taking other steps to prevent the further spread of COVID-19 in your school community. Sharing of information about you will only be done so in accordance with applicable law and city policies protecting the privacy and the security of your data.

Personal Information	
<b>Name:</b>	<b>Date of Birth:</b>
<b>Address:</b>	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
<b>Race:</b> <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Hawaiian/Pacific Islander	<b>Ethnicity:</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino
<b>School:</b>	<b>Role:</b> <input type="checkbox"/> Staff <input type="checkbox"/> Student
<b>Phone #:</b>	
<b>Email</b> (a copy of this form will be sent to this email address):	

**CONSENT**

By completing and submitting this form, I confirm that I am the appropriate legally authorized individual to provide consent and:

- I authorize the collection and testing of a weekly individual COVID-19 test during school hours, through the Increasing Community Access to Testing (ICATT) Program.
- I authorize the collection and testing of any individual PCR/molecular diagnostic test on me.
- I understand that all sample types will be non-invasive, short nasal swabs.

- I understand that I will be notified about the POSITIVE results of any individual diagnostic test for COVID-19.
- Regardless of test results, I MUST adhere to all COVID-19 school safety guidance, including mask-wearing and social distancing, and follow school protocols for isolating and testing in the event I develop symptoms of COVID-19.
- I understand that staff administering individualized testing have received training on safe and proper test administration. I agree that neither the test administrator nor **International Charter Academy of Georgia (ICAGeorgia)** nor any of their trustees, officers, employees, or organization sponsors are liable for any accident or injuries that may occur from participation in the COVID-19 testing program.
- I understand that I must stay home if feeling unwell. I acknowledge that a positive individual test result is an indication that I must stay home from school, self-isolate, and continue wearing a mask or face covering as directed in an effort to avoid infecting others. Dates of isolation will be assigned by the district contact tracing team.
- I understand the school system is not acting as my medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care, and treatment from my medical provider if I have questions or concerns, or if their condition worsens. I understand I am financially responsible for any care I receive from my healthcare provider.
- I consent for my name, COVID-19 test results, and all information included within this authorization to be released by and among ICAGeorgia and their contracted service providers, and public health agencies for the purpose of testing coordination, results notification, and other public health purposes.
- I understand that individualized testing may create protected health information (PHI) and other personally identifiable information (PII). Pursuant to 45 CFR 164.524(c)(3), I authorize and direct the testing provider to transmit such PHI to my school, the Department of Public Health, and the testing laboratory. I further understand that PHI may be disclosed to the Executive Office of Health and Human Services and any other party, as authorized under HIPAA.
- I understand that authorizing these COVID-19 tests for me is optional and that I can refuse to give this authorization, in which case, I will not be tested.
- This permission will be in effect from the date of my signature and at any time I am employed or enrolled in **ICAGeorgia** unless I terminate this authorization in writing. 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, please contact the school nurse.

Signature:	Print:	Date:
------------	--------	-------