Stephen F. Dockray
Superintendent-Director

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TRI • COUNTY

REGIONAL VOCATIONAL TECHNICAL HIGH SCHOOL
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MEMBER TOWNS:
Franklin, Medfield, Medway, Millis, Norfolk, North Attleboro, Plainville, Seekonk, Sherborn, Walpole, Wrentham

PARENT/GUARDIAN AUTHORIZATION FOR ADMINISTRATION OF COVID-19 TEST DURING SCHOOL

This consent is to be signed by parents/guardians of students under the age of 18.

By completing and signing this form, I confirm that I am the appropriate parent and/or guardian and that I authorize ________________________ (designated provider) to perform a COVID-19 test on my student during school hours on ________________ (date). I understand that authorizing a COVID-19 test for my student is optional. I can refuse to sign this authorization.

NAME OF STUDENT: ___________________________ DATE OF BIRTH__________________

ADDRESS: _____________________________________ TELEPHONE #: _______

Demographic Information:

The Department of Public Health is collecting the demographic information requested below.

What is the student's race? (Select all that apply):
____ American Indian/Alaskan Native
____ Asian
____ Black/African American
____ Native Hawaiian/Pacific Islander
____ White
____ Other
____ Unknown

Is the student of Hispanic origin? (Select one):
____ Yes
____ No
____ Unknown

What is the student's gender? (Select one):
____ Male
____ Female
____ Transgender
____ Unknown

Does the student have a disability? (Select one):
____ Yes
____ No

Is the student pregnant?
____ Yes
____ No

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Under the age of 18

What is the student's primary language? ________________________________

Emergency Contact:
In case of emergency, please notify:

____ ________________________________
Name Relationship to student

____ ________________________________
Address Telephone number

Parent/Guardian attendance at test (optional):
Please select one:

____ I will accompany my student in the mobile rapid response unit on the day of the COVID-19 test. I understand that I must wear a face/mask covering at all times and that I am not permitted to get tested.

____ I will not accompany my student in the mobile rapid response on the day of the COVID-19 test.

Test Results (please initial):
____ I recognize that the designated provider named above will share the test result with the student's parent/authorized representative and will report that result to the appropriate public health authority (the Massachusetts Department of Public Health and/or the student's local board of health) as required by state law.

Parents and guardians are encouraged to share the test results with the school department in order to promote public safety.

By signing, I confirm that my student is not showing signs of COVID-19 symptoms (such as fever, congestion, or nausea), and I have not been notified that my student was in close contact with anyone confirmed to be positive with COVID-19.

Authorized Signatory:

____
Parent/Guardian Name (Print)

____ ____________________
Parent/Guardian Signature Date