



Jack Mabley Developmental Center  
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**STUDENT/PARENT/GUARDIAN CONSENT FORM FOR COVID-19 REVERSE TRANSCRIPTION  
POLYMERASE CHAIN REACTION (RT-PCR)-/ANTIGEN TESTING**

The Illinois Department of Human Services (IDHS), Division of Rehabilitation Services (DRS), is seeking your voluntary consent to participate in regular and clinically indicated COVID-19 testing. Please carefully read the following:

**I understand** that COVID-19 is a respiratory illness that usually starts as fever and cough, however, in some people, severe complications may develop. COVID-19 seems to be spread by close person-to-person contact. This can occur when a person who is sick with COVID-19 coughs or sneezes onto themselves, other people, or nearby surfaces. Droplets from the cough or sneeze can travel a short distance through the air and land on the mouth, nose, or eyes of persons who are nearby. The virus also can spread when a person touches a surface or object with infectious droplets and then touches his or her mouth, nose, or eye(s). It also is possible that COVID-19 can be spread through the air or by other ways that we don't yet know about.

**I acknowledge** that I may be tested for COVID-19 because I have voluntarily requested to be tested by IDHS/DRS for possible COVID-19 infection

**I understand** the benefits of testing for COVID-19 are as follows:

1. The test may help detect the presence of COVID-19 infection, and enable me to seek appropriate medical attention, or
2. There may be no immediate direct benefits to me from having this test done. However, this test may help to find the virus in people who do not yet have all the signs of COVID-19. If people with the COVID-19 virus limit contact with other people, this can prevent others from getting sick. By having this test done, I may lower the chance of spreading the virus from me to my family, friends, colleagues, patients/residents/clients that I work with, and others. I may receive the same benefit from others taking the test.

**I acknowledge** that the test will involve either of the following COVID-19 tests /procedures:

1. Nasopharyngeal Swab for RT PCR : I will be asked to tilt my head backwards and hold still while a healthcare professional inserts a long (6 inch), thin applicator swab through my nose to the back of throat (pharynx). The applicator swab will be rotated for several seconds. Occasionally, if the sample was not adequate, the same swab may need to be used to collect a specimen from the other side of my nose. I understand that the test should not be done if I have a history of a recent nasal trauma, nasal surgery, have a severe deviated nasal septum, have chronically blocked nasal passages, and/or a bleeding condition. Complications of the test are rare and

usually not serious and may include mild to moderate discomfort, gagging, coughing, and possibly a mild nosebleed. The test material will be preserved and processed by the Illinois Department of Public Health (IDPH).

2. Anterior Nasal Swab for RT PCR: I will be asked to tilt my head backwards and hold still while a healthcare professional inserts an applicator swab into the anterior (approximately ½ inch) of my nose. This may also be performed myself through direct instruction from the healthcare professional. The applicator swab will be gently rotated for approximately 15 seconds. Occasionally, if the sample was not adequate, the same swab may need to be used to collect a specimen from the other side of my nose. Complications of the anterior nasal swab collection are rare and very minor and may include an uncomfortable feeling. The test material will be preserved and processed by the IDPH.
3. Antigen Testing: I will be asked to tilt my head backwards and hold still while a healthcare professional inserts an applicator swab into the anterior nostril (approximately ½ inch) of my nose. This may also be performed myself through direct instruction from the healthcare professional. The applicator swab will be gently rotated 5 times or more against the nasal wall then slowly remove from the nostril. Complications of the anterior nasal swab collection are rare and very minor and may include an uncomfortable feeling. The test material will be preserved and processed by the healthcare professional. A positive antigen test result is considered accurate when instructions are carefully followed, but there's an increased chance of false-negative results — meaning it's possible to be infected with the virus but have a negative result. Depending on the situation, the healthcare professional may recommend another test to confirm a negative antigen test result.

**I acknowledge** that the tests are highly accurate, so a positive test usually implies that I have COVID-19; however, there is a possibility of having a false positive test (test indicates illness, however, I may not actually have COVID-19) or a false negative (test indicates no illness, however, I actually do have COVID-19). In either situation, my health care professional and/or public health official will explore all necessary follow-up care. Should my test results come back as positive, I shall self-isolate according to CDC guidelines and consult with and, as needed, seek treatment from my healthcare professional(s). While awaiting the test results, if I develop symptoms of COVID-19 (such as a new cough, fever, chills, muscle aches, new onset of loss of smell/taste), I should self-isolate at my residence and immediately notify my healthcare provider(s). If I develop severe symptoms, including shortness of breath/difficult breathing, chest pain, and/or blue lips, fingers, and/or toes, I should seek emergency medical attention.

**I understand that** my PCR test results should be available within 3 to 7 days or antigen test results within one hour. In the case of positive result, I understand that I will receive notification immediately upon receipt. I further understand that no additional release of the results will be made without my express written authorization.

**I acknowledge** that I have had the opportunity to ask questions regarding this procedure and my questions have been fully answered.

**I understand** that for questions regarding testing and results, I will contact the Director of Health Services or Nursing Department.

Testing will be completed and interpreted by DHS/DRS. Testing results will be available to any employees of DHS/DRS with a legitimate educational interest, consistent with the Illinois School Student Records Act. Additionally, DHS/DRS will share the following information to the parties described below in the manner described below:

- Positive and negative test results, student name, student date of birth, and student address with the Illinois Department of Public Health via electronic transmission of this information using the Red Cap online reporting site. The purpose of this disclosure is to facilitate contact tracing and tracking of test usage.
- Positive test results, student name, student date of birth, and student address with your local county health department via facsimile transmission. The purpose of this disclosure is to facilitate contact tracing and to assist the local health department in monitoring community transmission metrics
- All positive and negative test results will also be shared with the student’s parent/guardian for the purpose of seeking additional medical treatment.

By signing this Voluntary Testing Consent & Acknowledgement, I (Parent/Guardian and Student), on my own behalf and on behalf of Student, agree to waive, release, indemnify, hold harmless, and covenant not to sue DHS/DRS, administrators, employees, agents, representatives, volunteers, insurers, assigns, and successors, with respect to any and all claims, charges, and causes of action, whether known or unknown, past, present, or future, including, but not limited to, any and all costs, expenses, and attorneys’ fees, by reason of any injury, illness, death, damage, or loss, arising out of or in connection with DHS/DRS’ administration of the COVID PCR/Antigen test to Student.

**ACCEPTANCE:**

**By my signature below, I understand and acknowledge the information above concerning the test and release of the results. I voluntarily agree to testing for COVID-19.**

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

Signature: \_\_\_\_\_

This acknowledgment will remain in effect for one (1) calendar year from the date it is signed unless revoked in writing.

**TESTING DECLINED:**

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

Relationship to Student: \_\_\_\_\_

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