NORTHWEST ARCTIC BOROUGH SCHOOL DISTRICT

INFORMED CONSENT
FOR COVID-19 ANTIGEN SCREENING FOR STUDENT ACTIVITIES

Student Last Name	Student First Name	Student Middle Initial
Date of Birth (mm/dd/yyyy)	Grade	Home Phone
Name of School	Parent/Legal Guardian Emergency Phone Number	

Please carefully read the following informed consent:

1. I am providing informed consent for the Northwest Arctic Borough School District and/or an independent laboratory acting on NWABSD's behalf to conduct antigen screening on _____ for exposure to the 2019 Novel Corona Virus (COVID-19).
2. I understand that antigen screening is a means to screen for possible COVID-19 exposure during in-person learning or during student activities events.
3. I acknowledge that my child will be antigen screened on a regular basis in order to be eligible to practice, play, or travel for student activities.
4. I acknowledge that my child can be antigen screened for COVID-19 without my presence when they attend NWABSD schools and activities.
5. In the event of a positive antigen screen, I acknowledge that my child will need to immediately receive a diagnostic COVID-19 test from Maniilaq or other healthcare provider. If the diagnostic test is negative for COVID-19, my child may return to school and student activities. If the diagnostic test is positive for COVID-19, my child will follow the healthcare provider guidance. If my student refuses a diagnostic test, my child will quarantine for 14 days and be symptom free before returning to school and will potentially have to do 5 separate day practices before being eligible to play in the next ASAA sanctioned event.

ACCEPTANCE

I, _____, hereby consent to _____ participating in periodic COVID-19 antigen screen through the NWABSD.

Signature	Relationship to student	Date (mm/dd/yyyy)
Address	Telephone Number	