INFORMED CONSENT TO TESTING

I, being the parent, legal guardian, or custodian of _____a minor child, hereby VOLUNTARILY CONSENT, and give authorization to, the Board of Education of Cicero School District 99 (the "District"), to conduct a saliva (spit) test to attempt to detect COVID-19 in my child. I understand that the information obtained during the course of the testing of my child will be released to but not be evaluated by the District, but will instead be evaluated by a third-party medical professional, who will review the results of this basic test to attempt to determine whether my child has COVID-19. I therefore further voluntarily consent for any third-party medical professional to review and evaluate the results from any such tests.

I acknowledge that this consent to testing is valid for one calendar year from the date of execution and the expiration of such consent does not otherwise effect or invalidate the waiver or release of any claims or matters contained herein.

NO GUARANTEE OF RESULTS; WAIVER AND RELEASE OF LIABILITY

I understand that even if the SHIELD saliva test is performed on my child, there is not a guaranteed certainty that COVID-19 would be detected by such test. I further understand that my child could contract COVID 19 after testing and thus it would go undetected by the test. THEREFORE, I ACKNOWLEDGE AND AGREE THAT THE DISTRICT CAN MAKE NO, AND DOES NOT MAKE AND EXPRESSLY DISCLAIMS, ANY WARRANTY OR GUARANTEE THAT IF MY CHILD HAS COVID-19, IT WILL BE DETECTED BY ANY OF THE TESTS BEING PERFORMED BY THE DISTRICT.

As such, I, on behalf of myself and my child, and our assignees, heirs, distributees, guardians, next of kin, spouse and legal representatives (the "Releasing Parties"), do hereby absolutely, fully, and forever release, relieve, waive, relinquish and discharge the District (as identified above), any medical professionals working in conjunction with the District, and any and all of their respective directors, officers, volunteers, agents, contractors, and representatives (the "Released Parties"), of and from any and all actions or causes of action, actual or alleged claims, of any kind or undiscovered, accrued or un-accrued, suspected or unsuspected, which any Releasing Party may now have claim to have, or which may at any time hereafter accrue, arising out of, in connection with, in consequence of, in any way involving, or related to the performance, interpretation and communication of the results of any of the tests or testing as described in this document, including but not limited to any failure to detect COVID-19 which results in the personal injury to or death of my child, whether due to the inherent limitations in the testing procedures, the negligence of any of the Released Parties, or otherwise. I also agree that I, my child, assignees, heirs, distributees, guardians, next of kin, spouse and legal representatives will not make a claim against, sue, or attach the property of any Release in connection with any of the matters covered by the foregoing release.

I recognize and acknowledge that I am responsible for taking appropriate follow-up and additional necessary actions on behalf of my child upon receipt of a positive test result, including but not limited to having additional tests performed on my child to confirm the result, meeting with my child's personal physician, and/or following quarantine procedures recommended by the Illinois Department of Public Health or other governmental organization(s).

I understand and acknowledge that I am free to have additional COVID-19 tests performed on my child at any time should I desire additional testing.

CONDUCT OF THE TESTING

In order to conduct the SHIELD saliva test on my child, I understand and acknowledge that the test administrator will need to collect saliva from my child. I hereby voluntarily consent to such form and manner of testing being conducted on my child. I acknowledge and understand that I, or my child, may stop any testing procedure at any time for any reason or for no reason.

Should any medical event or emergency occur during the testing, while every effort will be made to contact the parent/guardian/custodian, I hereby consent to any treatment which might become necessary as a result of a medical event or emergency while my child is a participant in the testing. I understand that health/accident coverage is the responsibility of the participant or their parent/guardian/legal custodian.

RELEASE OF RESULTS

I also hereby voluntarily give consent to the District to take any actions necessary due to the SHIELD saliva test results and understand that my child's name will not be released at anytime regarding such results without my prior written consent unless otherwise required pursuant to the Illinois Department of Public Health and/or any other laws or regulations. Furthermore, I consent to the inclusion of the results of any testing performed on my child in a data bank which will be used to perform further research and investigations into COVID-19 as well as help to control the spread of the virus. I understand that this data will be used for a scientific purpose and will receive only impersonal statistical treatment and that my child's individualized personal data will not be revealed to another person without my prior written consent or pursuant to the previously listed requirements. Further, I recognize that I can disclose participation and/or testing results at any time without penalty of any kind.

NAME:_____

SIGNATURE:_____

DATE:_____