

Northwest Christian Schools of Lacey



Permission Form for COVID PCR and Rapid Testing

Patient Name:

Patient Birthdate:

NCP NCA NCHS NCS

Home Address:

Phone Number:

Northwest Christian Schools of Lacey (NCS) has collaborated with the Washington State Department of Health to be able to offer free COVID testing to students and staff.

The COVID tests are shallow nasal swabs, which are quick and painless, and will be self-administered under observation by a trained person. A company called Curative will process and analyze the PCR test results and will share the results with NCS and the patient. Our rapid tests will be administered on campus and results will be available shared with the patient via text or email. Positive results (PCR and rapid tests) are shared with the LHJ in accordance with Washington State Law.

By signing below, you authorize Curative to release the results of your COVID PCR test results to Northwest Christian Schools of Lacey. This information will be used for the purpose of addressing the health and safety of students and staff through medical surveillance of COVID cases in our school.

By signing below, you also authorize yourself to be tested if you have had symptoms or had exposure to a positive individual and for NCS to have Curative process and analyze the test (PCR Tests). You further authorize NCS to share information and your birthdate with Curative for identification purposes. You acknowledge and understand that schools and childcare settings are required to share positive results (PCR and rapid tests) with the LHJ in accordance with Washington State Law. Finally, you understand that, per the Washington State Department of Health, a student or adult with COVID or COVID symptoms cannot attend school onsite.

By signing below, you affirm that you have the legal authority to determine who may receive the protected health information pertaining to the patient.

Printed Name:

Signature:

Date:

Received by NCS on: NCS Employee Initials:

Please complete both sides of this form and return to the NCS office on or before test date.



CURATIVE LABS COVID TESTING AUTHORIZATION

You are entitled to keep your child's protected health information private. This Authorization Form allows you to grant third-party access to your child's protected health information that otherwise would not be permitted.

By indicating your consent below, you authorize Curative Inc., and Curative Labs, LLC, as applicable, to disclose your child's protected health information described below to the persons or entities identified in this form.

I hereby authorize the release of the following protected health information:

- My name; and
- The result of my COVID (novel coronavirus) test

This information may be released to:

- Northwest Christian Schools of Lacey (NCS)
- Me, as the legal personal representative, via SMS though I acknowledge that texts are not secure
- Me, as the legal personal representative, via email though I acknowledge that emails are not secure

This information will be used for:

- Addressing the health and safety of our students through medical surveillance of COVID cases at our schools.

I also understand and agree to the following:

- I may refuse to provide this authorization.
- Any information used or disclosed through this authorization may no longer be protected by privacy laws and may be subject to re-disclosure by the person or organization receiving it.
- I have the right to revoke this authorization at any time by doing so in writing to support@curativeinc.com.
- Any revocation of this authorization by me will not apply to actions that Curative Inc. and Curative Labs, LLC, or Dr. Sajad Zalzal M.D. has already taken regarding the sharing of my protected health information during the period that my authorization was valid.
- This authorization will remain in effect for one (1) year from the date it is signed unless otherwise revoked.

I have read and had an opportunity to ask questions about this authorization.

By signing below, I affirm that I have legal authority to authorize who may receive my protected health information.

My Name:

My DOB (MM/DD/YYYY):

Date:

Signature: