

## **Hermon-DeKalb Central School**

709 E DeKalb Road, DeKalb Junction, NY 13630

Phone: (315) 347-3442 Fax: (315) 347-3817

September 27, 2021

Dear Parents/Guardians,

Starting October 4, school districts in the county will offer weekly testing for students in our building at no cost to you. St. Lawrence County has provided our school with the self-administered **Quadrant BioSciences** saliva tests. These can be used to screen students for COVID-19 weekly right here at school. These tests are short swabs in the cheek region. Students will perform the test themselves while being overseen by our nurse. Tests will be sent to Upstate Medical and results will be available in 24-48 hours. Once the tests are administered here at school, all results will be available for parents on an online portal.

**Participation in the testing program is strictly voluntary. Students must be pre-registered with Quadrant Biosciences prior to participation in this testing.**

Please read through the testing consent form included and return it to Nurse Jill as soon as possible **and** follow the directions to register your student online for testing.

Again, this is a voluntary testing program being offered to our students. Please contact Nurse Jill or me with any questions.

Mark White

Superintendent

## **How to Register your Child for Voluntary Weekly COVID-19 Test**

Our weekly saliva testing starts in October. We ask that you complete the online registration below as soon as possible. Without this registration and profile, your test can not be processed.

\*\*Please have your insurance card with you prior to beginning as it will ask for insurance information. You will not be billed a co-pay or for the testing, but your insurance will be as they are reimbursed with federal funds for the test.

### **STEPS**

1. Go to [app.clarifi-covid-19.com](http://app.clarifi-covid-19.com)
2. Click Register and create an account
3. Click "add a profile" and complete the screens for your profile. Be sure you select Hermon-DeKalb Central School as your organization.
4. You will not need to "Add a COVID-19 test" prior to testing. This will be completed on-site on the day of testing.
5. \*\*Please Note: You will be asked to provide Health Insurance information, but you will not be billed for this test. Quadrant Biosciences will be seeking reimbursement directly from your health insurance provider.

IF YOU ARE UNABLE TO REGISTER ONLINE PLEASE SEE NURSE JILL FOR ASSISTANCE.

Once you have completed your profile you are all set. When all samples have been collected for the day, we will send them off to Quadrant's lab to be analyzed. Results will be returned within 24-48 hours and will be available for you to view by logging back into [app.Clarifi-COVID-19.com](http://app.Clarifi-COVID-19.com).

### **Things you should not do before testing:**

**1 hour before-** Brush your teeth or use mouthwash.

**30 minutes before** No food or drink

## School COVID-19 Testing Consent Form

Quadrant BioSciences saliva tests will be used at our school for students on a weekly basis. This test requires a self-administered cheek swab sample to be collected. The sample is then sent out and tested to find out if the person has COVID-19 and results are obtained in approximately 24-48 hours. This test information as well as student demographics are then uploaded to the NYS database. **This testing program is strictly voluntary.**

Please carefully read the following informed consent:

1. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a cheek swab, as ordered by an authorized medical provider or public health official on my child.
2. I authorize my child's test results to be disclosed to the school, county, state, or to any other governmental entity as may be required by law.
3. I acknowledge that a positive test result is an indication that my child must self-isolate in an effort to avoid infecting others.
4. Testing does not replace treatment by a medical provider. I assume complete and full responsibility to take appropriate action with regard to my test results. I agree I will seek medical advice, care, and treatment for my child from my medical provider if I have questions or concerns or if my condition worsens.
5. I understand that, as with any medical test, there is the potential for false-positive or false-negative test results.
6. I, the undersigned, have been informed about the test purpose, procedures, possible benefits, and risks. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to testing for COVID-19.

### To be Completed by Parents

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M F  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I give my permission for my school to collect a sample from me and test for COVID-19.

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

Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return this signed form to Nurse Jill.**