AUTHORIZATION TO USE AND EXCHANGE COVID-19 INFORMATION

ALL LINE ITEMS MUST BE COMPLETED & RETURNED TO SCHOOL NURSE/DAYCARE ADMINISTRATION

Name of Staff or Student/Attendee _____
(FULL PRINTED NAME)

Name of Parent/Guardian _____ School/Daycare Name_____

I am authorizing that in the event I (staff) have / my child (student/attendee) has COVID-19, the following confidential information may be exchanged:

- ✓ My name and school/daycare
- ✓ COVID-19 test result, date of test, and date of illness
- ✓ Date of birth _____
- ✓ Home address _____
- ✓ County or City in which I live _____
- ✓ Phone number(s) _____ (for Health Dept. to reach you)
- ✓ Email address(es) _____ (for Health Dept. to reach you)

I request that School/Daycare Administration and the following entities be able to use and exchange this information among themselves for public health purposes:

- ✓ Alexandria Health Department
- ✓ My Local Health Department (based on home residence)
- ✓ Testing Provider (Doctor or Hospital)

CHECK ONE:

- ☐ **I authorize** the release of the information above as it pertains to a COVID-19 diagnosis, in order to facilitate COVID-19 contact investigations and related safety/infection control responses performed at my school/daycare, with the understanding that my/my child's personal information and protected health information will not be disclosed to parties not directly involved with the public health investigation. I understand that I have the right to revoke this authorization in writing at any future date.

- ☐ **I <u>do not</u> authorize** the release of the information above as it pertains to a COVID-19 diagnosis, in order to facilitate COVID-19 contact investigations and related safety/infection control responses performed at my school/daycare. I understand that I can revise this declination at any future date, and understand that with the authorization my/my child's personal information and protected health information will not be disclosed to parties not directly involved with the public health investigation.

Signature: _____ Date: _____

Full Printed Name: _____

PLEASE COMPLETE ENTIRELY

Incomplete Forms Will Delay the Future Public Health Response

Return completed forms to School Nurse / Daycare Administrator (or designee)

Diocese of Arlington, the School, their clergy, administrators, employees, agents, members and volunteers ("Indemnitees") from any and all claims, damages, demands, and causes of action, present orfuture, known or unknown, anticipated or unanticipated, in any way related to exposure to COVID-19 while participating in School activities, including but not limited to any claims of negligent exposure.
This includes claims that arise from my own and others' acts, actions, activities and/or omissions, excepting only those that arise solely from the gross negligence, recklessness or intentional torts of Indemnitees, and those that are both (a) not asserted by our child or family or any member thereof, and
(b) not alleged to arise from our acts or omissions. With respect to claims alleged to arise from our acts oromissions, our agreement to defend, indemnify and hold harmless the Indemnitees shall be effective only in the event that I, my child, or a member of our family is determined to be liable for such acts or omissions under applicable law, or by agreement. I will defend and indemnify Indemnitees with respect toany released claim, including but not limited to damages, costs and attorney's fees.

Responsibility for Health Screening

By execution of this Statement, I affirm that my or my child(ren)'s presence at School on any day constitutes an affirmative representation on my part that I/we have performed all health screening stepsrequired by the School for attendance or participation in School activities.

I understand that on any day when my child(ren) does not pass the required health screening (which mayinclude questions relating to other members of the household as well as my child(ren)), I and/or my child(ren) are not permitted to participate in in-person School activities.

Need to Inform and Quarantine

I understand, in the event that I/my child is suspected or confirmed positive with COVID-19 or has come in close contact with a person suspected or confirmed positive with COVID-19, I/my child will need to follow the CDC's guidance for isolation or quarantine as implemented by the Virginia Department of Health and local health departments. Information is available at www.cdc.gov. I agree to inform the School administration as soon as possible, but no later than one (1) business day, after learning of my/mychild's suspected or confirmed positive case of COVID-19 and/or the need to quarantine due to close contact with a person suspected or confirmed positive for COVID-19. I understand that I/my child may not return to in-person School activities until approved by School Administration. Approval will be basedon confirmation by the local health department that the CDC's criteria to discontinue home isolation or quarantine has been met.

Authorization and Informed Consent

I hereby authorize the School to enforce such other reasonable measures and directives as may be deemednecessary by the Bishop of the Diocese of Arlington, its Office of Catholic Schools, or the School leadership.

By execution of this Agreement, I understand and agree to the foregoing terms and conditions. Student

Signature (if 18 or older): _____

Parent/Legal Guardian Signature: _____

Date: _____