INDEMNIFICATION AND PERMISSION SHEET

1. In consideration for receiving the opportunity to participate in COVID-19 testing (hereinafter "Testing"), which is provided by the company HR Support, Inc. (together, hereinafter "Company"),
2. I _____(herein "Participant') hereby release, waive, discharge, covenant not to sue, and
   (First and last name of self if over 18 / parent or legal guardian if under 18)
   agree to hold harmless for any and all purposes Company and their healthcare staff, members, shareholders, officers, servants, agents, volunteers, or employees from any and all liabilities, claims, demands, injuries, or damages, including court costs and attorney's fees and expenses, that may be sustained by me while participating in Testing, while traveling to and from the Testing, or while on the premises owned or leased by the property owner of the test site.
3. I am also fully aware that Company is not providing medical care or giving a medical diagnosis based on the results indicated from Testing and that ***I should consult my doctor or go to an emergency room if have any serious symptoms and/or to obtain medical advice as to the results of the Testing.*** If the Testing produces a negative result, it does not preclude the possibility that I have COVID-19 or that I may develop it in the future, and I am aware I should obtain further testing if I develop any symptoms or come in contact with anyone who may have COVID-19. I choose to voluntarily participate in Testing with full knowledge of these facts. I know of no medical reason why I should not participate.
4. To the extent necessary to complete the Testing and to allow Company to provide information related to the Testing to appropriate government authorities or non-profit entities who are studying COVID-19, I hereby waive my rights regarding protected health information under HIPAA. Protected health information ***will*** not be reused or disclosed by Company to any person or entity other than above, except as required by law.
5. VOLUNTARY SIGNATURE. In signing this agreement I acknowledge and represent that I have read it, understand it, and sign it voluntarily as my own free act and deed; Company has not made and I have not relied on any oral representations, statements, or inducements a part from the terms contained in this agreement.
6. ***Your test result should be texted to you within 48 hours if done (Monday-Friday) but if done on Saturday or Sunday, expect result the following week. Due to unforeseen circumstances the time frame may vary.***

Please provide the following information for the individual being tested:

*First Name: _____ *Last Name: _____ *Sex: _____ *Date of Birth: ____/____/____
M / F / Other *MM / DD / YYYY*

Race/Ethnicity: (circle one) American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian & Pacific Islander / White / Unknown / Other

*Residential Address: _____
House Number, Street Name, Apt Number *City* *State* *Zip Code*

Email Address: _____ Mobile Number: (_____)_____-_____

Each person who registers will need to use their own unique email and mobile number in order to receive automated results. By providing your email address and mobile number you consent to receiving messages to the number provided.

Do you have any of the following symptoms? Please check all that apply:

Cough ☐ Chills ☐ Headache ☐ Diarrhea ☐ Shortness of breath or difficulty breathing ☐ Repeated shaking with chills ☐ Sore throat ☐
Vomiting ☐ Fever ☐ Muscle pain ☐ New loss of taste or smell ☐ N/A ☐

Have you been in close contact with someone who tested positive for COVID-19 in the last two weeks? Yes ☐ No ☐

Have you been tested for COVID-19 before? Yes ☐ No ☐

INSURANCE: (circle one) Commercial / Medicaid / Medicare / MediCal / Other / None

Name of Insurance Carrier: _____

Policy or Member Number: _____ Group ID: (If applicable) _____

Policy Holder's Name: _____ Relationship to policy holder: (circle one) Self / Spouse / Minor

*Bring a copy of (over 18) your / (under 18) your parent or legal guardian's **Government Photo ID***

*Bring a copy of your **Insurance Card** or by signing below, "I attest that I don't have insurance"*

Signature _____

Date: _____

*Signature or Parent/Legal Guardian Signature: _____ Date: _____

HIPAA Privacy Authorization:

I, _____(Signature or Parent/Legal Guardian Signature), consent to have HR Support, Inc., and Avellino Lab USA, Inc. disclose my child/dependent's COVID-19 test results to the Stockton Unified School District for the 2021 calendar.

Signature or Parent/Legal Guardian Signature: _____ Date: _____