ANCHORAGE SCHOOL DISTRICT
CONSENT FORM FOR COVID-19 TESTING AND AGREEMENT TO COMPLY WITH TESTING PROTOCOL

I certify that I am the parent or legal guardian of the minor child listed below or am over the age of 18 (the "Participant"). In consideration of the benefits associated with participating in ice hockey, I hereby give my consent and permission to have Participant test for the 2019 novel corona virus ("COVID-19") on a regular basis pursuant to the testing protocol implemented by the Anchorage School District ("ASD") at a designated testing site ("Testing") during the entirety of the 2021 ice hockey season. This testing protocol may be based on the directives mandated by the Municipality of Anchorage, including Emergency Order No. 19, Attachment E, version 3, or may be more rigorous that these directives.

I understand that if Participant fails to comply with ASD's testing protocol, they may be prevented from participating in practices or competitions. ASD reserves the right to supplement and amend its testing protocol and I agree to comply with all such changes. I further agree to let ASD know immediately if Participant, or anyone in Participant's household, tests positive for COVID-19 and/or exhibits any of the commonly known symptoms of COVID-19, such as fever, cough, shortness of breath, fatigue, muscle aches, and other such symptoms.

I agree to release, waive, discharge, indemnify, and hold harmless ASD, their healthcare staff, volunteers, employees, agents, representatives, and contractors, specifically including Capstone Family Medicine, LLC or any other company working with ASD to implement the tests, from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and reasonable attorneys' fees and expenses, that may be sustained by Participant while participating in Testing.

I am fully aware that the Testing may involve certain tests that have not gone through a full FDA approval process and instead obtained emergency use authorization (EUA) and that the results could produce false positives or false negatives, or be administered in a way that otherwise produces inaccurate results. I am also fully aware that I should consult a doctor or go to an emergency room if Participant has any serious symptoms and/or obtain medical advice from my own doctor as to the results of the Testing.

I hereby waive Participant's rights regarding protected health information under the Health Insurance Portability and Accountability Act (HIPAA), to the extent necessary to complete the Testing and to allow ASD to provide the results of the Testing (whether positive or negative) to (1) the Anchorage School District; (2) local and state public health authorities (which may result in further direct communication from those entities to me for further follow-up and contact tracing); and/or (3) any other entity required by law. Protected health information will not be reused or disclosed by ASD to any person or entity other than above. I further agree that, to the extent the result of the Testing is a student record protected by the Family Educational Rights and Privacy Act (FERPA), I expressly agree to waive all such privacy protections by allowing the disclosures set forth above.

ON BEHALF OF MYSELF, THE PARTICIPANT, AND EACH AND EVERY ONE OF THE PARTICIPANT'S HEIRS, REPRESENTATIVES, EXECUTORS, ADMINISTRATORS, AND ASSIGNS, UNEQUIVOCALLY ASSUME ALL RISKS RELATED TO TESTING, INCLUDING BUT NOT LIMITED TO THE RISKS IDENTIFIED ABOVE, THAT MAY ARISE OUT OF OR PERTAIN TO TESTNG THE PARTICIPANT.

WARNING: This Agreement is a binding contract preventing you, the Participant, and your collective heirs, representatives, executors, administrators, and assigns from bringing any lawsuit against ASD arising out of or pertaining to the Participant's participation in Testing, including but not limited to any negligence claims. This document affects your substantial legal rights and remedies. Please read it carefully before signing.

FULLY UNDERSTANDING ALL OF THE ABOVE, AND WITH REASONABLE TIME TO SEEK ASSISTANCE IN UNDERSTANDING THIS AGREEMENT, I UNEQUIVOCALLY AGREE TO THE TERMS OF THIS AGREEMENT.

Name of Participating Student: _____

Signature of Parent or Legal Guardian/Participant if Over 18: _____

Printed Name of Parent or Legal Guardian/Participant: _____