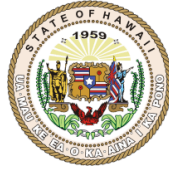


David Y. Ige
GOVERNOR



Keith Hayashi
INTERIM SUPERINTENDENT

STATE OF HAWAII
DEPARTMENT OF EDUCATION
PĀHOA HIGH AND INTERMEDIATE SCHOOL
15-3038 PĀHOA VILLAGE ROAD
PĀHOA, HI 96778
808-313-4300

Aloha PHIS Parents and Families,

We hope that your family is in good health and your child(ren) are adjusting to school.

Our school is part of a new program called Operation Expanded Testing which will help us get a more accurate understanding of the spread of COVID-19 in our community. We will have free, weekly COVID-19 testing available on our campus for students. If your child is showing symptoms of covid-like illness, or have been identified as a close contact of a covid-positive individual, do not come to school. Seek testing at an alternative location.

Who can participate: Participation is open to all school staff, students, contracted workers, and volunteers. Participation is completely voluntary and students may test every week for as long as the program runs if they choose, but they are not required to test every week.

Registration: Families can register their students to participate in advance at <https://home.color.com/covid/sign-up/start?partner=hhs-787-300-Students>. By registering online, parents/guardians will be providing consent for their child to participate. We will also provide the same link at pahoahis.org. **If you do not register in advance at the link, your student will have to come with the attached forms signed.**

Testing: The test is simple and painless, and is conducted with a nasal self-swab. Samples are then collected for processing without any physical interaction between students and staff.

Results: After the testing is complete, all samples are shipped to a lab for processing. Parents will be able to find their child's test results in about 48 hours by visiting the [Color COVID Testing](#) link on our homepage at pahoahis.org. Test results are also shared with the school administrator and the Department of Health, for the purposes of contact tracing. These agencies are expected to adhere to all HIPAA confidentiality (privacy) requirements.

Scheduling: Student testing will happen 7:30-7:55 AM, 10:00-10:20 AM, and 12:30-1:00 PM on Wednesdays in front of the health room at our school. No appointment is necessary.

Kim Williamson
Principal, PHIS

HIPAA Authorization

Authorization to Disclose Health Information

Background

PerkinElmer, Inc., and its affiliates (collectively, “PerkinElmer”) and collaborators including Color Health, Inc. (“Color” and together with PerkinElmer and other participants the “Providers”), is providing Covid-19 testing and related services (the “Covid-19 Services”) at the request of the institution that is paying for or otherwise making the Covid-19 Services available to you (e.g., the employer, school, or entity for which you perform or will perform services, or will enter their facilities) (the “C19 Program Sponsor”) to help guide the C19 Program Sponsor’s determination about the safety of admitting individuals to their facility/facilities during the Covid-19 pandemic (the “Authorized Use”). In connection with the Covid-19 Services, you will share certain personal and health information (“Protected Health Information” or “PHI”) with Providers through this software platform operated by Color. For purposes of this authorization, your PHI also includes the information that Providers generate about you in performing the Covid-19 Services, including your Covid-19 test results. Purpose of this Authorization To facilitate and execute the Covid-19 Services, and as required or permitted by applicable law, rule, or order, by signing this authorization form, you authorize Providers to share your PHI with other Providers and with the C19 Program Sponsor in connection with the Authorized Use, each time the Covid-19 Services are performed.

Expiration of Authorization:

This authorization will expire after five (5) years from the date of your authorization.

Your Rights:

By signing this authorization form, you understand and acknowledge the following:

- I understand that I am not required to sign this authorization form, but that my refusal will make me ineligible to receive the Covid-19 Services through the C19 Program Sponsor’s program.
- I may revoke my authorization at any time, but to do so, I must request my revocation via electronic mail to support@color.com. My revocation will take effect upon Color’s receipt, except to the extent that Color has taken action in reliance upon this authorization prior to my revocation.
- I have received a copy, or have the right to receive a copy, of this authorization or to inspect the information contained therein by contacting support@color.com.
- I understand that PerkinElmer is receiving payment from the federal government, and that PerkinElmer is paying other Providers in connection with the Covid-19 Services.
- I understand that this authorization shall apply for each instance that Providers perform the Covid-19 Services for me, including, but not limited to, sharing my PHI with the C19 Program Sponsor each time I take a Covid-19 test if I repeat testing through the C19 Program Sponsor’s program.

- I understand that the information disclosed pursuant to this authorization may no longer be protected by federal or state medical confidentiality laws if the recipient of my PHI is not subject to such laws and may be re-disclosed by the recipient.

Parent Consent form for Minor Students

Pahoa High and Inter

I acknowledge that I have read, understood, and agree to

<https://www.color.com/covid19-informed-consent>, <https://www.color.com/covid19-tos>, <https://www.color.com/notice-of-privacy-practices> and <https://www.color.com/privacy-policy>.

I understand that my agreement to each of these applies each time I take a Covid Test through my Covid Testing Program Sponsor's program over the next six (6) months, as explained in the COVID-19 Informed Consent, unless I contact support@color.com to revoke my consent for subsequent testing.

In my capacity as the patient's parent/guardian, I acknowledge that I have read, understood, and agree to the Terms of Service, and that my agreement to it applies for this Covid Test and each subsequent time the patient takes a Covid Test through his or her Covid Testing Program Sponsor's participation in the PerkinElmer testing program, as explained in the COVID-19 Informed Consent, unless I contact support@color.com to revoke my consent for subsequent testing.

I authorize the patient's information and results to be shared with the patient's school, congregate living facility, or other collection site organization to guide decisions on health, safety, and/or returning to work/school (read full HIPAA authorization above). I understand that this authorization applies to this instance and each subsequent time the patient gets tested through this program. I certify that I am this patient's parent/guardian and that I have the legal authority to consent to sharing their information and results.

I understand that the patient's personal and health related information (including the patient's results) will be shared with clinical and other staff at the testing site, as well as all federal, state and local bodies as required by applicable law, for treatment and follow-up care purposes.

Patient/Student Name (Please Print): _____

Patient/Student Signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____