Please carefully read the following informed consent:

I, on behalf of myself or my minor son/daughter/legal dependent (the “student”), authorize Heluna Health and/or any Heluna Health approved vendor or independent laboratory acting on Heluna Healths behalf to conduct collection and testing for exposure to the 2019 Novel CoronaVirus (COVID-19) through a mid-turbinate nasal swab, saliva sample, or other minimally or non-invasive sample collection method as ordered by an authorized medical provider. The consent provided allows for voluntary testing.

- I authorize on behalf of myself or my child COVID-19 testing by collecting a nasal swab. Most children and adults will swab the first inch or so of their nose themselves.

- I understand that Heluna Healths independent laboratory partners are operating, as permitted under applicable laws and regulations, at various stages of the U.S. Food and Drug Administration’s Emergency Use Authorization submission, acknowledgment, and approval process. By signing below, all Parties agree to be contacted via telephone and text message.

- I acknowledge that, if the student receives a positive test result, I must ensure that the student abides by all applicable federal, state and/or local requirements with respect to isolation and quarantine to avoid infecting others.

- I further acknowledge that, in the event of a positive test, Heluna Health and/or individuals or contractors acting on its behalf, may contact me and those who may have been exposed to the student and the student’s identity may be disclosed to certain individuals to the extent necessary to protect the health and safety of those exposed.

- I understand that by signing this document and agreeing that the student shall undergo COVID-19 testing, that I am not creating a patient relationship with Heluna Health and/or individuals or contractors acting on its behalf, I understand that Heluna Health is not acting as a medical provider for the student. Testing does not replace treatment by a medical provider. I assume complete and full responsibility to take appropriate action with regards to the test results for the student. I agree I will seek medical advice, care and treatment from a medical provider for the student to the extent such medical advice, care and treatment becomes necessary.

- I understand that, as with any medical test, there is the potential for false positive or false negative test results to occur.

- I understand that Heluna Health has engaged certain third-party contractors and consultants to assist it in administering its COVID-19 testing program. I further understand that in order for the COVID-19 testing program to be successfully administered, certain personal information regarding the student will need to be communicated to such contractors and consultants for purposes of administering the program, and only to the extent necessary to the administration of the COVID-19 testing program. This includes certain information contained within HIPAA compliant data management software and may include personally identifiable information protected under the Family Educational Rights and Privacy Act, including student name, school, grade level, and cohort. I hereby expressly authorize such

information regarding the student to be disclosed as described herein to the extent necessary to the administration of the COVID-19 testing program.

- I understand that neither I nor my family will be charged directly for services.

- To the maximum extent allowed under applicable law, I hereby release, waive, hold harmless, and covenant not to bring a suit against Heluna Health or Primary or any of the administrators, sponsors, organizers, volunteers, employees, agents, or any affiliated individuals or entities associated with this screening from any and all losses, damages, liabilities or other claims or causes of action that may arise out of my participation.

- By signing this form, I acknowledge that I have received a copy of Heluna Healths's Notice of Privacy Practices. Medical records will be kept in a confidential manner; however, I acknowledge that Heluna Health may release information regarding treatment to third party payors such as Medi-Cal or insurance companies for the purpose of billing. I also understand that public information such as immunization history and/or communicable disease may be shared with the school nurse to protect the health of other students. I understand information may also be disclosed to third parties to facilitate the testing program and the transmission of electronic health records.

ACCEPTANCE

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 consent, and I have been told that I can ask other questions at any time. I, on behalf of the student, voluntarily agree to testing for COVID-19.

HELUNA HEALTH NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you or your child may be used and released and how you can get access to this information. Please review this document carefully.

Heluna Health and its contract agencies/schools are required by federal law, the Health Insurance Portability and Accountability Act (HIPAA), to make sure that your Protected Health Information (PHI) is kept private. PHI includes information that we have created or received about you or your child’s past, present, or future health/medical conditions that could be used to identify you or your child. Unless you give us written authorization, we will only release your health/medical information for treatment, payment, or health care operations or when we are otherwise required or permitted by law to do so. Not every use is listed, but the ways we can use, and release information fall within one of the descriptions below.

- Appointment reminders and health-related benefits or services: We may use PHI to send you appointment reminders. We may also use PHI to give you information about other health care related treatment and services.

- Treatment: We may use and release your PHI to those who provide you with health care services or who are involved with you or your child’s care such as doctors, nurses and other health care professionals. PHI may also be used for referrals to hospitals, specialists, or for other treatment alternatives. For example, we may share the PHI with relevant school staff for Individualized Educational Program (IEP) purposes to recommend appropriate Special Education related services to address your child’s health needs while at school.

- To receive payment for the treatment that was provided to you or your child: We may use and release your PHI in order to bill and receive payment for treatment and services you or

your child received in the school or community setting. For example, LAUSD bills Medicaid for services that are provided to Medi- Cal eligible students.

- Health Care Operations: We may use and release your PHI in order to administer our school-based health centers. For example, members of our quality improvement team may use information in you or your child's health record to review the care and outcomes for quality improvement purposes.

- To meet legal requirements: We may use and release PHI to government officials or law enforcement agencies when federal, state, or local laws require us to do so. We also share PHI when we are required to do so in a court or other legal proceedings. For example, if a law says we must report private information about students who have been abused, we will provide such information.

- To report Public Health activities: We may use and release PHI to government officials in charge of collecting certain public health information. For example, we share general information about immunizations, deaths, and some statistical information about diseases such as pertussis or chickenpox.

For Research Purposes: We do not release PHI for purposes of medical research. We do, however, use PHI to create a collection of information that cannot be traced back to you or your child.

Name of participant:_____Date:_____

Signature of participant:_____

AND/OR

Name of parent/guardian:_____Date:_____

Signature of parent/guardian:_____