



How to register for an at-school COVID-19 test

The process

- 1 Choose one of three ways to begin registration**
Scan the QR code to the right, go to Walgreens.com, or visit the Walgreens app.
- 2 Click on the “get started” button**
- 3 Agree to terms and conditions**
- 4 Enter patient/contact information and COVID-19 test voucher codes**
Use the Plan and Group ID as they are displayed below:



Scan me!

Students
Plan ID: RNYCOV19
Group ID: RNYSOAK

- 5 Complete HIPAA Authorization**
Consenting will allow the school district to view the results of the test.
- 6 Fill out a quick questionnaire**
- 7 Select a testing location**
At-school testing
Select an available time/day shown to register for a COVID-19 test at participating school locations. Walgreens will be on school sites once a week.

NOTE

Please move through the dates and select the date with the first timeslot available. Please select any available date and time.

What to expect

The process: Walgreens will offer drive-thru testing at select Walgreens locations and will come to your school on a weekly basis to facilitate testing. Testing is always optional.

The test: Testing is self-administered and non-invasive. Shallow nasal swabs will be used to collect samples.

The results: PCR results are typically available within 48 hours. Results will be provided via email.

Your role: For at-school testing, a one-time registration is required for testing on school sites and weekly appointments are required in case you choose to be tested at one of our store locations (with provided testing voucher codes).

*COVID-19 testing is available to students, teachers, and staff ages 3+ at no cost. Patients will not receive a bill from Walgreens or any lab partner. If you receive a Diagnostic Test and have insurance, you will be asked to show your insurance card at the appointment and the lab may bill your insurer. State and federal programs may also provide no-cost testing in your area, visit Walgreens.com/StateFundedTesting to view a current list of our government-sponsored testing partners.



At-school COVID-19 testing

FAQs



Your school is conducting recurring screening testing for COVID-19, in partnership with Walgreens.

Screening tests are intended to identify infected people who are asymptomatic and do not have known, suspected, or reported exposure to SARS-CoV-2. Screening helps to identify unknown cases so that measures can be taken to prevent further transmission¹.

Why is screening for COVID-19 important?²

Screening is the only way we can find and isolate people without symptoms before they spread the virus to others. Individuals with COVID-19 can be infectious for 2- 3 days before they show symptoms. These individuals are *pre-symptomatic*. In addition, up to 50% of children and 20% of adults infected with COVID-19 never show any symptoms at all – they are a-symptomatic. **Screening in schools is a way to prevent disease spread in the community.** By screening at the school, we are helping to protect families that are sending their children to school. Any COVID-19 cases we are able to find and isolate are cases that will not be able to spread further in the community.

Who is eligible for COVID-19 testing?

All students, faculty and teachers of RCSD Rochester City School District are eligible to be tested. To find a location and make an appointment, visit Walgreens.com/covid19testing.

How often will testing happen?

Testing will occur weekly during school hours on a specific day of the week as determined by the school.

What kind of test will be used?³

Diagnostic Lab Test (PCR): The RT-PCR Diagnostic Panel Test - NAAT is used to detect genetic material (mRNA) of the coronavirus and will be sent to a laboratory to determine results in a variable amount of time. Participants perform a simple, shallow nose swab in each nostril. A Walgreens Pharmacy team member will be available to provide verbal coaching through the process.

Do I need to use the testing voucher codes I received?

Yes! It is crucial that you utilize the testing voucher codes provided for testing registration online. The voucher codes tell our Walgreens partners that the individual tested is a part of the Rochester City School District. Additionally, the testing voucher codes unlock a unique digital experience only available to the Rochester City School District.

Should I receive a test if I have symptoms of illness?¹

Individuals who are experiencing 1 or more symptoms of illness may not come to school. They can still get tested at a Walgreens drive-thru test location in your area. The Walgreens drive-thru testing sites available in your community offer both Rapid Diagnostic Test (ID NOW™): The Rapid Point-of-Care (POC) - NAAT (ID NOW™) and Diagnostic Lab Test (PCR). To find a location and make an appointment, visit Walgreens.com/COVID19testing.

How quickly will we get back test results?

Results are typically available within 48 hours via the email used to register the student.

I tested positive, what do I do?

If you test positive, you should call physician immediately. You will need to isolate for at least 10 days depending on the course of the virus. You will also be contacted by your local Department of Health.

¹ Screening Testing. [Testing Strategies for SARS-CoV-2 | CDC](https://www.cdc.gov/media/releases/2021/s111121-covid-19-testing.html). Updated Mar. 11, 2021. Last accessed May 6, 2021.

² [Operational Strategy for K-12 Schools through Phased Prevention | CDC](https://www.cdc.gov/media/releases/2021/s042321-covid-19-schools.html). Updated Apr. 23, 2021. Last accessed May 6, 2021.

³ [Nucleic Acid Amplification Tests \(NAATs\). Nucleic Acid Amplification Tests \(NAATs\) | CDC](https://www.cdc.gov/media/releases/2021/s041621-covid-19-testing.html). Updated April 16, 2021. Last accessed May 6, 2021

Will my results be shared with the school?

Yes. If you provide universal HIPAA authorization during registration, the results will be shared back to the school each week. Patients may still receive a test if HIPAA authorization is not provided.

Will I receive a bill for the test?

No, you will not receive a bill from Walgreens or any lab partner at any time. Testing is free* to all students, staff, and teachers of the Rochester City School District.

Can my friends and family receive a test?

Your friends and family cannot receive a COVID-19 test using the testing voucher codes provided by the school. However, free* community testing is available at a Walgreens drive-thru test location in your area. To find a location and make an appointment, visit [Walgreens.com/COVID19testing](https://www.walgreens.com/COVID19testing).





AUTHORIZATION – FOR RELEASE OF INFORMATION TO THIRD PARTY

This Authorization is for use, pursuant to the HIPAA privacy rules, if you are authorizing the release of medical/health information to a third party, such as a school. You understand these records may contain information created by other persons or entities, including physicians and other health care providers as well as information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services (excluding psychotherapy notes), reproductive health services, and treatment for sexually transmitted diseases.

Section 1: Patient information

Patient Name: _____
Date of Birth: _____
Street Address: _____
City, State, Zip: _____
Telephone Number: (____) _____ E-mail Address: _____

Section 2: Person/organization authorized to receive information from Walgreens (“Designated Entity”)

Name: Rochester City School District
Street Address: 131 West Broad Street
City, State, Zip: Rochester NY 14614
Telephone Number: (585) 262-8100 E-mail Address: COVID.Response@rcsdk12.org

Section 3: Describe or list the information that you are asking us to release

My/the patient’s COVID-19 laboratory test results.

Section 4: List the specific purpose for requesting this information

I am currently associated with the Designated Entity and request that the Designated Entity receive my/the patient’s COVID-19 laboratory test results.

Section 5: Expiration Date (see instructions)

This authorization expires: One year from the date of my signature

For Maryland residents only: This Authorization will expire one year from the date listed below in Section 7.



Section 6: Information regarding this Authorization

- You have the right to revoke this Authorization, in writing to Walgreens Privacy Office, at any time. The revocation is only effective after it is received and logged by Walgreens. Any use or disclosure made prior to a revocation is not included as part of the revocation.
- Refer to our Notice of Privacy Practices for permitted uses and disclosures of protected health information (“PHI”). You may obtain a copy of this Notice from the Privacy Office or on www.walgreens.com. Please keep a copy of this authorization for your records.
- **Once PHI is disclosed to others, it may be redisclosed by them to persons or entities that are not subject to the privacy regulations, which means that the PHI may no longer be protected by regulations.**
- Privacy regulations prohibit the conditioning of treatment, payment, enrollment, or eligibility for benefits on signing this Authorization.
- This Authorization must be signed and dated by the patient or signed and dated by the patient’s personal representative to include a description of that person’s ability to act on behalf of the patient.

Section 7: Signature

By signing below, I authorize Walgreens to use or disclose of my protected health information of _____ as described above.

Signature

Date

Section 8: If this Authorization is signed by the patient’s personal representative, please explain your authority to act. If you are signing the authorization as the legal representative of the individual listed in Section 1, and are other than the parent of the minor child whose information you are authorizing Walgreens to release, you must also submit documentation that establishes yourself as the legal representative. For example, a copy of a Power of Attorney that includes provisions to obtain medical information, etc.

School name: School of the Arts
 Walgreens ID/site # for school: 60048
 Address: Price St and Erion Crescent
 Rochester, NY 14607

Barcode or Unique Identifier Affixed Here

COVID-19 Registration Form
Formulario de Solicitud para Prueba de COVID-19

No other test may be ordered on this COVID-19 requisition form
 No se puede ordenar ninguna otra prueba en este formulario; este es un formulario de solicitud solo para prueba de COVID-19

Test Name: COVID-19 Nombre de la Prueba: COVID-19		Sample Type: Nasal Swab Tipo de Muestra: Hisopo nasal	
1. Individual Tested (Select One) <i>Persona que se Sometió a la Prueba (Selecciona uno)</i> <input type="checkbox"/> Student (<i>Estudiante</i>) <input type="checkbox"/> Teacher (<i>Maestro(a)</i>) <input type="checkbox"/> Staff member (<i>Miembro del Personal</i>)		2. Grade (Grado) _____ <input type="checkbox"/>	
3. First Name (Nombre)		4. Last Name (Apellido)	
5. Gender (Select One) <i>Género (Selecciona Una)</i> <input type="checkbox"/> Male (<i>Masculino</i>) <input type="checkbox"/> Female (<i>Femenino</i>) <input type="checkbox"/> Other (<i>Otro</i>)		6. DOB(MM/DD/YYYY) / / <small>Fecha de nacimiento (MM / DD / AAAA)</small> MM / DD / YYYY	
7. Race (Select One) <i>Raza (Selecciona Una)</i> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White			8. Ethnicity (Etnicidad) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino <input type="checkbox"/> Decline to Answer
9. Address (Dirección)		10. City (Ciudad)	11. State (Estado)
12. Zip Code (Código postal)	13. County (Condado)	14. Phone (Teléfono) _____ - _____ - _____ Circle one: Cell (Móvil) Home (Casa) <small>(Encierra uno en un círculo)</small>	

Walgreens Team Member Use Only (Para uso de un miembro del equipo de Walgreens solamente)

Pharmacist Name:	
Pharmacist NPI:	
Date of Collection:	Time of Collection:
Completed minor informed consent to participate (if under 18 years old): YES NO	
Completed HIPPA Authorization to release test results to school: YES NO	
Provided test result to individual tested (or parent/legal guardian if under 18 years old): YES NO	

SECTION A Student/staff member information; please print clearly.

First Name: _____ Last Name: _____

Phone: _____ Cell Home

Home Address: _____

City: _____ State: _____ County: _____ ZIP Code: _____

Date of Birth: ____/____/____ (MM/DD/YYYY) Age: _____

SECTION B

CONSENT

By completing and submitting this form, I confirm and certify that I am either: (a) the parent or legal guardian of the above-designated minor student; (b) the legal guardian of the above-designated minor student; or (c) a teacher/staff member, at Rochester City School District and that:

- A. I consent to and authorize the testing of the above-designated individual for the novel coronavirus (SARS-CoV-2) on a weekly basis during school hours for the duration of the testing program.
- B. I consent to and authorize the use of any individual clinical diagnostic tests for the novel coronavirus (SARS-CoV-2) on the above-designated individual, including but not limited to the Abbott ID NOW rapid molecular test, Abbott BinaxNOW rapid antigen tests and PCR (laboratory) tests. I acknowledge that: (i) I am aware that the test involves self-administration of a nasal swab to capture mucus and secretions from the above-designated individual; and (ii) use and administration of the swab is a low risk procedure. On behalf of myself, my heirs and personal representatives, and the above designated individual, I hereby release and hold harmless Walgreens and each of its employees, contractors, agents, successors, divisions, affiliates, subsidiaries, officers, and directors, from any and all liabilities or claims whet her known or unknown arising out of, in connection with, or in any way related to any of either myself, the above designated individual, or the Rochester City School District school nurse administering a nasal swab to capture mucus and secretions from the above designated individual for use in testing for the novel coronavirus (SARS-CoV-2).
- C. I understand that consenting to and authorizing the testing of the above-designated individual for the novel coronavirus (SARS-CoV-2) is optional and that I can refuse to give this authorization, in which case, the above-designated individual will not be tested.
- D. I understand that I can change my mind and cancel this consent and authorization at any time, but that such cancellation is forward-looking only, and will not affect my consent and authorization to tests already conducted or information I already permitted to be released. To cancel this consent and authorization for COVID-19 testing, I need to contact the front office at the Rochester City School District.
- E. I consent to and authorize the provider conducting the test to monitor aspects of the novel coronavirus (SARS-CoV-2) virus, such as tracking viral mutations, by sequencing viruses and other microbes present in the sample(s) for epidemiological and public health purposes. Results of such analyses will not be personally identifiable nor create personally identifiable information.
- F. I understand that the above-designated individual's participation in this testing and any records developed as a result of participation that could be used to identify the above-designated individual are confidential and will be maintained in confidence.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this COVID-19 Screening Test Consent Form. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to and authorize testing for novel coronavirus (SARS-CoV-2) for the above-designated individual.

Patient Signature: _____ Date: _____

Parent (if minor) or Legal Guardian (if applicable) Signature: _____

Print Name (Parent or Legal Guardian): _____ Date: _____



AUTORIZACIÓN – PARA LA DIVULGACIÓN DE INFORMACIÓN A TERCEROS

Esta Autorización se usa, conforme a las normas de privacidad de la HIPAA, si está autorizando la divulgación de información médica/de salud a terceros, como lo es una escuela. Usted entiende que estos registros pueden incluir información generada por otras personas o entidades, incluyendo médicos y otros proveedores de atención médica, así como información relacionada a servicios de tratamiento para el abuso de drogas y alcohol, tratamiento contra el HIV/AIDS, servicios de salud mental (excluyendo notas de psicoterapia), derechos de salud reproductiva, y tratamiento para enfermedades de transmisión sexual.

Sección 1: Información del paciente

Nombre del paciente: _____
Fecha de nacimiento: _____
Calle y número: _____
Ciudad, estado y código postal: _____
Número de teléfono: () _____ Correo Electrónico: _____

Sección 2: Persona/organización autorizada a recibir información de parte de Walgreens (“Entidad Designada”)

Nombre: Rochester City School District
Calle y número: 131 West Broad Street
Ciudad, estado y código postal: Rochester NY 14614
Número de teléfono: (585) 262-8100 Correo electrónico: COVID.Response@rcsdk12.org

Sección 3: Describa o enumere la información que nos está pidiendo divulgar

Mis resultados/los resultados del paciente de la prueba de laboratorio de COVID-19.

Sección 4: Anote el propósito específico de solicitar esta información

Actualmente, estoy asociado con la Entidad Designada y solicito que la Entidad Designada reciba mis resultados/los resultados del paciente de la prueba de laboratorio de COVID-19.

Sección 5: Fecha de expiración (vea las instrucciones)

Esta autorización expira: Un año a partir de la fecha en que la firmé
Solo para residentes de Maryland: Esta autorización expirará un año a partir de la fecha indicada abajo en la Sección 7.



Sección 6: Información sobre esta Autorización

- *Tiene el derecho de revocar esta Autorización, por escrito a la Oficina de Privacidad de Walgreens, en cualquier momento. La revocación solo es efectiva luego de que Walgreens la reciba y la registre. Cualquier otro uso o divulgación hecha antes de la revocación no se incluye como parte de la revocación.*
- *Refiérase a nuestro Aviso de Prácticas de Privacidad para conocer cuáles son los usos y las divulgaciones permitidas de la Información Médica Protegida (PHI, por sus siglas en inglés). Puede solicitar copia de este Aviso a la Oficina de Privacidad o en www.walgreens.com. Por favor, conserve una copia de esta autorización en sus archivos.*
- ***Una vez que la Información Médica Protegida se divulga a otros, estos la podrían divulgar nuevamente a otras personas o entidades que no están sujetas a las normas de privacidad, lo que significa que la Información Médica Protegida podría dejar de estar protegida por dichas normas.***
- *Las normas de privacidad prohíben condicionar el tratamiento, pago, inscripción o elegibilidad para recibir beneficios a la firma de esta Autorización.*
- *Esta autorización debe ser firmada y fechada por el paciente o firmada y fechada por el representante personal del paciente, y debe incluir una descripción de la capacidad de esa persona para actuar en nombre del paciente.*

Sección 7: Firma

Al firmar abajo, autorizo a Walgreens a usar o divulgar mi siguiente información médica protegida _____ como se describe arriba.

Firma

Fecha

Sección 8: Si esta Autorización es firmada por el representante personal del paciente, por favor, describa su autoridad para actuar. Si está firmando esta Autorización como representante legal de la persona nombrada en la Sección 1, y no es el padre o la madre del menor cuya información está autorizando a Walgreens a divulgar, también debe someter la documentación que lo establezca como el representante legal. Por ejemplo, una copia del poder notarial que incluya disposiciones para obtener información médica, etc.