COVID-19 Testing Registration Process

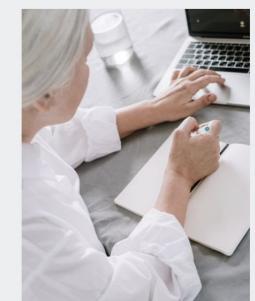




Registration Link - Specific to each sport



Welcome to the NCAA Gymnastics COVID-19 Testing Site



Username	10	
	Forgot username?	
Password	B	
	Forgot password?	
	Log on	
	1	Olial, have
Register		I JUCK DEFE
Register Every individual tha separate account.	t is registering for a test must create a	Click here



Authorization



G Select Language

Terms and Conditions

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that Impact Health generates personal health information ("PHI") that will be disclosed under this Authorization and that such disclosure is conditioned upon my execution of this Authorization. I understand that the purpose of creating the previously identified PHI is related to COVID-19 tests or immunizations and that disclosure may be required to designated entities described below (the "Designated Entities"). I further understand that if I do not agree to this Authorization, I may not be able to receive a COVID-19 test or immunization at this time. I hereby authorize and consent to the following use and disclosure of my PHI to the listed Designated Entities:

a) my PHI may be used or disclosed by Impact Health to a clinical laboratory ("Lab"), if applicable, for the analysis and interpretation and reporting my test results; and,

b) Impact Health and/or the Lab, if applicable, may disclose the fact that I have been tested for COVID-19 in this screening program and my test results to (i) my employer (or host company, as the case may be) or any of its subsidiaries and (ii) federal, state, and local agencies, to the extent permitted under the Americans with

Disabilities Act ("ADA") and applicable federal, state, and local laws and regulations and to protect the safety and well-being of those persons working on-site at my employer (or host company, as the case may be) or any of its subsidiaries.

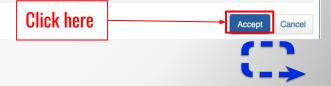
I understand that I have the right to revoke this authorization at any time by delivering written notice of my intent to revoke to: Impact Health, 1009 West Ninth Avenue, Suite A, King of Prussia, PA 19406, Attention: Privacy Practices.

I understand that this Authorization will be executed through the use of an electronic click assent, the use of which, expressly indicates my intent to execute this document in accordance with the Electronic Signatures in Global and National Commerce Act (E-Sign Act), Title 15, United States Code, Sections 7001 et seq., the Uniform Electronic Transaction Act (UETA), and any applicable state law, and that any electronic click assent will be deemed an original signature for purposes of this Authorization, with such electronic click assent having the same legal effect as an original signature.

This authorization is effective at the date of my click assent and shall remain in effect for one year, unless I revoke my authorization in the manner provided.

I understand that I have a right to receive a copy of this authorization and I certify that a copy of this authorization has been made available to me.

I HAVE CAREFULLY READ THIS AUTHORIZATION AND FULLY UNDERSTAND ITS CONTENTS AND AUTHORIZE IMPACT HEALTH TO RELEASE PHI TO THE DESIGNATED ENTITIES FOR THE PURPOSES LISTED ABOVE. I EXPRESSLY CONSENT TO THE USE OF ELECTRONIC CLICK ASSENT AND UNDERSTAND THAT BY CLICKING "I AGREE," I HAVE AFFIRMATIVELY EXECUTED THIS AUTHORIZATION AS IF I HAD PROVIDED AN ORIGINAL SIGNATURE ON THIS DOCUMENT.





Registration

te the following	information.	
School	School dropdown list	~
Gender	Male O Female O Not specified	
ate of Birth	2 digit month, 2 digit date, 4 digit year	
First name	Enter First Name	6
Last name	Enter Last Name	- B
ail address	Email address that can be retrieved via mobile device	l)
firm e-mail	Email address that can be retrieved via mobile device	- B
ephone no	Phone #	B)
Address	Street Address	Ð
	Street Address 2	[¹
City	Enter City	B)
State	State Drop Down	~
ZIP	Enter Zip	10
	Click here	or Cancel



Choose your username and password



Set Username/Password

Your registration request has been accepted and you now need to choose a username and password that you will need to enter each time you return to the site. Please enter the username and password you would like to use and click on 'Sign in' to enter the site. Your registration is not complete until you have chosen your username and password.

- · Password must include both upper and lower case letters.
- · Password must include at least one number.
- · Password must be at least 6 characters long.
- Previous 7 passwords cannot be reused.

Username	WhatEverUWant	B
Password		l)
Confirm password		ß
•	Click here	Sign in Cancel





Consent

Welcome, Dan

G Select Language

Decline

Terms and Conditions

INFORMED CONSENT TO PARTICIPATE IN COVID-19 TESTING

I wish to take part in today's health screening program, which is being conducted by Impact Health Biometric Testing, Inc., ("Impact Health") a CLIA-waived laboratory and Diamond Health, Inc.

I understand that, in addition to information I will provide on a questionnaire, this health screening program will require me to provide personal information and that I will be subjected to a clinical test that is intended to diagnose COVID-19.

I understand that the test requires inserting one or more swabs in my nasal cavity(ies) which may result in some discomfort.

I understand that the results of the test will be analyzed, interpreted, and provided to me by Impact Health and/or Diamond Health, Inc., together with a copy of the Fact Sheet for Patients required by the FDA. I understand that Impact Health, Diamond Health, Inc. will disclose my COVID-19 laboratory results to Stratoscope Consulting LLC (or any of its subsidiaries) in connection with Stratoscope Consulting LLC's ongoing initiatives to protect the health and safety of all individuals participating in this event.

I understand that the results of this health screening are for information purposes only and do not constitute the diagnosis of COVID-19 or any other disease, illness or health condition, which diagnosis can only be made by a qualified physician or other licensed healthcare provider. I also understand that I should not use the results of this health screening program as a substitute for seeking further information, diagnosis or reatment from or by my physician or other qualified physiciare provider.

I agree that the transmission and receipt of information during or after this screening program, including any communication via the Internet or e-mail, does not constitute or create a doctor-patient or other healthcare professional relationship between me and Impact Health or any other entity involved in this screening program.

I, my heirs, and personal representatives, waive and release Impact Health, Diamond Health, Inc., and Stratoscope Consulting LLC, its partners and affiliates, in connection with this program, and their subsidiaries, affiliates and parent corporations and their respective officers, directors, agents or employees, from any and all claims, demands or causes of action for damages or injuries that I may have or later acquire against Impact Health, Diamond Health, Inc., and Stratoscope Consulting LLC or such other entities resulting from or arising out of my participation in this health screening program, including my presence at the testing site, the results of the screening or any services or communications provided in connection with this health screening program.

I understand that my test results, the information provided on this form and my responses to the questionnaire ("my Personal Information") will not be used in a manner inconsistent with the Authorization for Use and Disclosure of Protected Health Information.

I understand that this Informed Consent Form will be executed through the use of an electronic click assent, the use of which, expressly indicates my intent to execute this document in accordance with the Electronic Signatures in Global and National Commerce Act (E-Sign Act), Title 15, United States Code, Sections 7001 et seq., the Uniform Electronic Transaction Act (UETA), and any applicable state law, and that any electronic click assent will be deemed an original signature for purposes of this Authorization, with such electronic click assent having the same legal effect as an original signature.

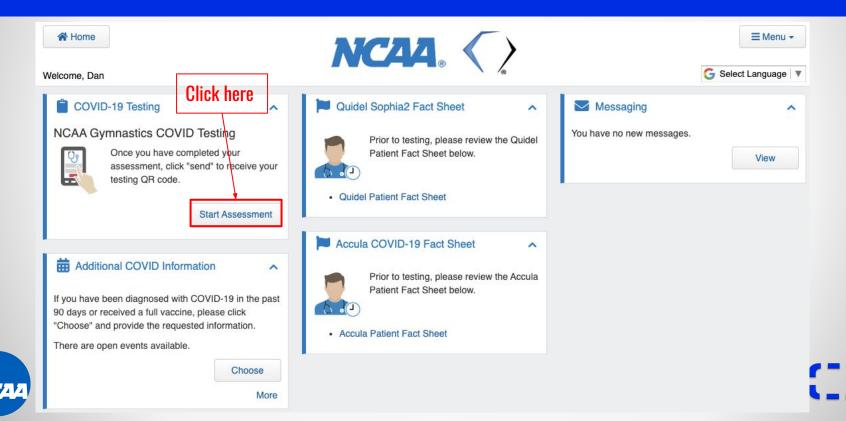
I HAVE CAREFULLY READ THIS INFORMED CONSENT FORM AND FULLY UNDERSTAND AND AGREE WITH ITS CONTENTS. I EXPRESSLY CONSENT TO THE USE OF ELECTRONIC CLICK ASSENT AND UNDERSTAND THAT BY CLICKING "I AGREE," I HAVE AFFIRMATIVELY EXECUTED THIS INFORMED CONSENT FORM AS IF I HAD PROVIDED AN ORIGINAL SIGNATURE ON THIS DOCUMENT.



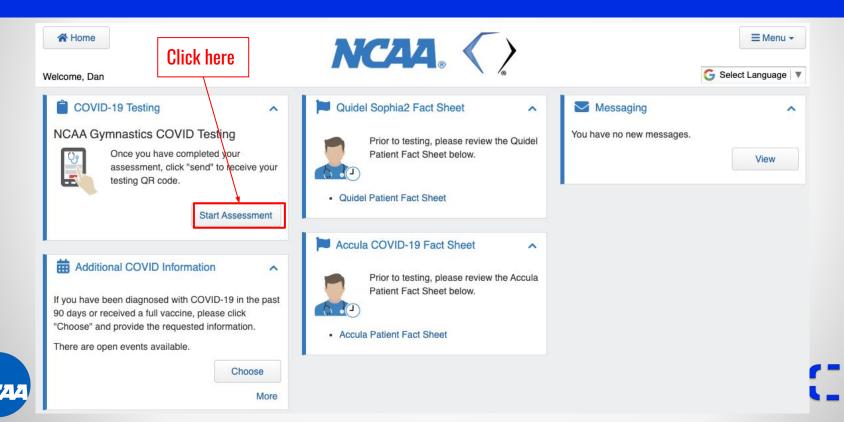




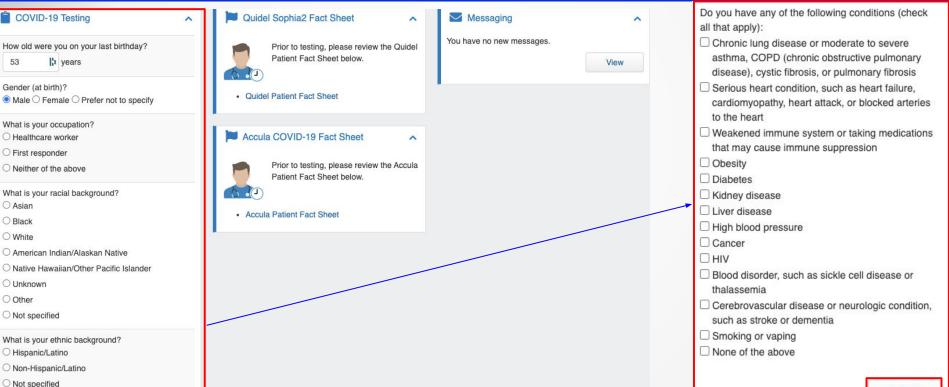
Home Screen



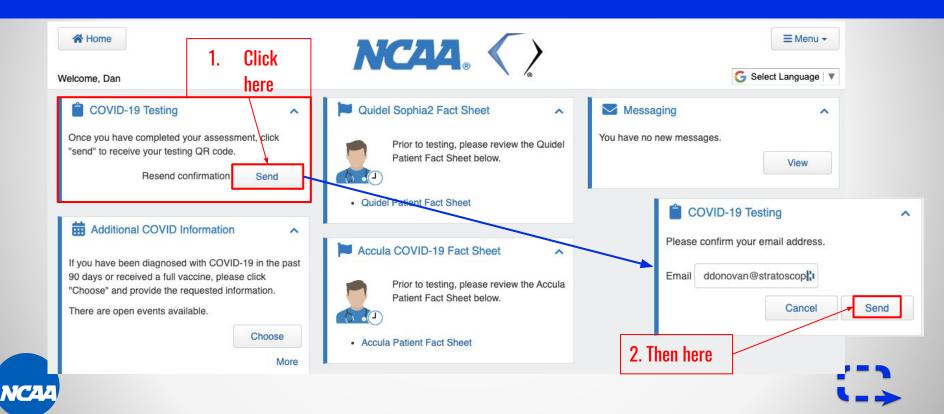
Adding Demographic Information



Assessment



Send Confirmation



Confirmation Email

Impact Health

> To: Dan Donovan

Saturday, Mar 27, 6:27 PM

Check your spam folder. If the QR code doesn't display check your security settings.

Dear Dan,

Please find your testing QR code below. Please present this QR code upon entering the testing area.



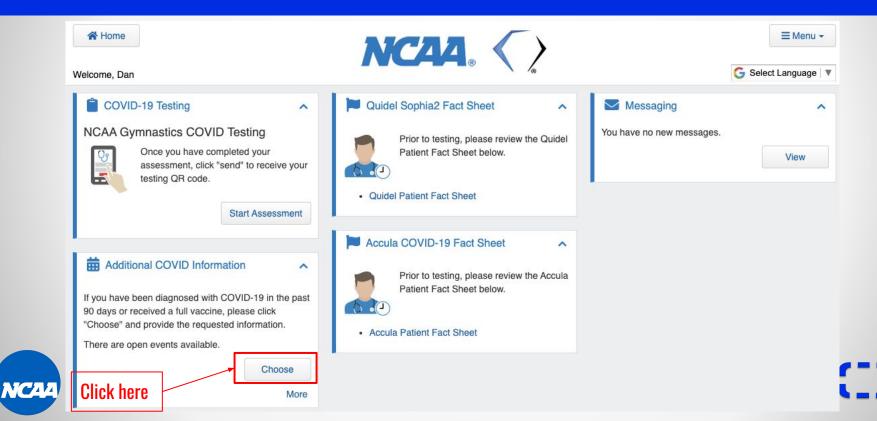
Thank you,

Impact Health

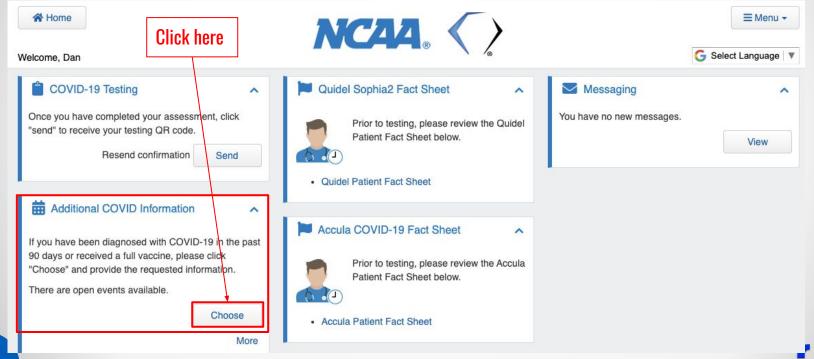




Add 90 day, Vaccinated and Pre-Travel



Additional $\Box O \vee ID$ Information



NCAA

Addn'l Info Screen

	Additional COVID Information
	If you have been diagnosed with COVID-19 in the past 90 days or received a full vaccine, please click "Choose" and provide the requested information.
	There are open events available.
	Choose
	Less
	Open Upcoming Recorded
	Compliance with Pre-Arrival Testing Attestation
	Record now Please complete to record compliance with NCAA Pre-Arrival requirements.
	About Record
	Full Cycle Vaccine Completed
	Record now Please complete if you have completed a full cycle of both vaccines (if applicable).
	About Record
	Positive Test in past 90 days
NCAA	Record now Complete if you have tested positive for COVID-19 in the past 90 days.
	About Becord

Additional COVID Information

Compliance with Pre-Arrival Testing Attestation

Open date:Mar 19

Completed:

I have completed the event requirements.

By checking the box, I attest that I understand and comply with all NCAA pre-arrival testing requirements applicable. I also understand that I may be asked to provide test results and/or other documentation in support of this attestation of compliance at any time before, during or following the event and agree to respond to any such request within a reasonable amount of time.

Cancel Record

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Additional COVID Information

Full Cycle Vaccine Completed
Open date:Nov 1

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Did you complete a full cycle of both vaccines as applicable?:

Completed:

Attach file

Choose File No file chosen

I have completed the event requirements.

I have completed a full cycle of both vaccines (if applicable) for COVID-19.

*Please upload your vaccine documentation and respond with yes and the date of your final vaccination.

Cancel Record



Positive Test in pa	ist 90 days
Open date:Mar 1	
Did you Test positive for CO	VID in past 90 days:
Completed:	#
Attach file	
Choose File No file chosen	
I have completed the even	t requirements.
I tested positive for COVID-19	within the past 90 day
*Please upload your test result and your date of diagnosis	s and respond with ye

Cancel Record