COVID-19 Diagnostic Testing Consent

Student's Full Name: _______________________________________ DOB: __________________

Building _______________________ Grade___________ Teacher ____________________________

Parent/Guardian Full Name: ____

Relationship to Student: ____

Home Address: ____

Contact number: ____

Diagnostic testing is intended to identify current infection in individuals and should be performed on anyone that has signs and symptoms consistent with COVID-19 or has been exposed to COVID-19.

☐ **YES, I DO give consent for my child to be tested for COVID-19**

☐ **NO, I DO NOT give consent for my child to be tested for COVID-19**

IF YOU CHECKED "YES" ABOVE, PLEASE SIGN BELOW:

- I attest that: I have signed this form freely and voluntarily, and I am legally authorized to make decisions for the child named above.
- I consent for my child to be tested for COVID-19 infection.
- I understand that my child's test results, and other information may be disclosed as permitted by law.
- I understand that if I am a student age 18 or older, or may otherwise legally consent for my own health care, references to "my child" refer to me and I may sign this form on my own behalf.

Signature of Parent/Guardian: _______________________________________ Date: _____________
(if child is under age 18)

Signature of Student: ____ Date: ____________________
(if age 18 or over or otherwise authorized to consent)

B-G CSD Staff Name________________________________**Signature**______________________________________
(If consent was provided verbally or via telephone by authorized parent/guardian**)**