

COVID-19 STUDENT TESTING CONSENT FORM

STUDENT PARTICIPANT INFORMATION

Student's Full Name: _____ Grade: _____

Student's Birth Date: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Full Name: _____ Relationship to Student: _____

Home Phone: _____ Cell Phone: _____

PLEASE CHOOSE ONE OF THE BELOW OPTIONS:

Yes, I agree: I give my consent for my child to be tested for COVID-19. I understand this allows my child to be tested at my student's school and personal submission of the test results to the district.

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

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: _____
(if child is under age 18)

Date: _____

Signature of Student: _____
(if age 18 or over or otherwise authorized to consent)

Date: _____

