COVID-19 PCR AND ANTIGEN TESTING CONSENT FORMS

Section 1: Information about Child to Receive Testing (please print)

STUDENT'S NAME (Last)	(First)	(M.I.)	STUDENT'S DATE OF BIRTH month_____ day_____ year_____	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	STUDENT'S AGE	STUDENT'S GENDER M / F
ADDRESS				
CITY	STATE	ZIP	PARENT/GUARDIAN DAYTIME PHONE NUMBER:	
STUDENT'S DOCTOR'S NAME *(Last, First)* *Address* *City* *Zip*				
SCHOOL NAME	HOMEROOM/TEACHER'S NAME	GRADE		

Section 2: Test Screening

Please mark YES, NO, or DON'T KNOW for each question.

Please answer all the questions below	YES	NO
1. Is your child fully vaccinated?		
2. Has your child previously tested positive for COVID-19?		

Section 3: Consent

CONSENT FOR CHILD'S COVID-19 TEST: Please check one of the boxes below, then sign and date.

- ☐ I GIVE CONSENT to the NAME OF ORGANIZATION CONDUCTING CLINIC and its staff for my child named at the top of this form to be tested for the COVID-19 virus. (If this consent form is not signed, then you child will not be tested)
- ☐ I DO NOT GIVE CONSENT to the NAME OF ORGANIZATION CONDUCTING CLINIC and its staff for my child named at the top of this form to be tested for the COVID-19 virus.

Signature of Parent/Legal Guardian _____

Date: Month_____ Day_____ Year_____