COVID-19 Testing Consent Form

THIS FORM MUST BE RETURNED TO YOUR CHILD'S SCHOOL

PLEASE COMPLETE THE INFORMATION BELOW

Florida HEALTH Alachua County

Full, Legal Name of Student *(First Name Middle Initial, Last Name)* Please Print	Name of School
Parent/Guardian Name (*First Name Middle Initial. Last Name*) Relationship to Student	Grade Sex
Street Address Email Address	Student's Birth Date (MM/DD/YYYY) Age
City Zip Code	Home Phone # Cell Phone #

☐ **INSURANCE** ☐ **MEDICAID (Prestige, United Health Care, Stay Well/Wellcare, or Sunshine)** ☐ **MY CHILD DOES NOT HAVE HEALTH INSURANCE**

Insurance Company:	Member ID:
Policy Holder's Name:	Policy Holder's Date of Birth:

Race: (Circle One) American Indian/Alaskan Native Asian Black Hispanic Native Hawaiian/Pacific Islander White Other

This consent form authorizes your child to be tested for SARS-CoV-2, the virus that causes the novel coronavirus COVID-19.

Why is my child being tested?

Your child is being tested because she/he has signs or symptoms consistent with COVID-19 or has had contact with or suspected exposure to another child or adult who is infected with COVID-19.

How is the test conducted?

Samples for testing will be collected by using a nose swab (small swab put into the nose) and/or an oral swab (a small swab of the back of the throat). Testing will be performed on children who have symptoms that may be due to COVID-19, or on children who may have been exposed to a child who has COVID-19.

By signing this form, I agree to the following:

a. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a nasopharyngeal swab (a swab in the nose) or an oral swab (a swab in the throat), as ordered by an authorized medical provider or public health official. I understand that my child may be tested as often as determined necessary by an authorized medical provider or public health official. This consent extends to all COVID-19 testing performed during the 2022-2023 academic year.

b. I authorize my child's test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.

c. I acknowledge that a positive test result is an indication that my child must self-isolate and wear a mask or face covering as directed.

d. I understand the testing unit is not acting as my child's medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action when I receive my child's test results. I agree I will seek medical advice, care and treatment from my child's medical provider if I have questions or concerns, or if my child's condition worsens.

e. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

f. I understand that there will be no out-of-pocket cost for this testing but that my insurance will be billed for the test.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent and the Notice of Privacy Practices. I understand that this Consent allows the Florida Department of Health, Alachua County Health Department to use private health information for treatment, payment and health care operations as defined in the Notice of Privacy Practices. 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 COVID-19 testing for my child.

_____	_____	_____
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date

AREA FOR OFFICIAL USE ONLY

Symptomatic/Asymptomatic **(Circle One)**
Oral / Nasal **(Circle One)**

Signature/Title: _____
Date Collected: _____