COVID-19 Testing Consent Form

Name of school: _____ Grade: _____

In Office DX

Purpose:

To prevent the spread of COVID-19, testing, contact tracing, and isolation of infected people supports the health and safety of the community. The purpose of this "Child COVID-19 Testing Consent Form" is for parents or legal guardians to consent to COVID-19 testing for their children for the improved safety of each child, their school, and the whole community.

Authorizations:

- I authorize this testing unit to conduct collection and testing for COVID-19 through a nasal swab—less than one inch into the nostril—to screen for COVID-19.

- I authorize this testing unit to share my child's test results with my child's school for the sole purposes of identifying others who may have been exposed. I understand my child's test results will be shared with the Maricopa County Public Health Department or to any other governmental entity the law requires. The release of any legally privileged and confidential records (e.g. educational and/or medical records) will be in accordance with applicable privacy protection laws, including the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA).

Acknowledgements:

I assume complete and full responsibility to take appropriate action with regard to my child's test results. I acknowledge a positive test result is an indication my child must self-isolate. I understand, as with any medical test, this COVID-19 test has the potential for false positive (test is positive but my child does not have the infection) or false negative (test is negative but my child has the infection) results. I agree to seek medical advice, care, and treatment from my healthcare provider if I have questions or concerns or if my child's condition worsens. I understand the testing unit is not acting as a healthcare provider, and this testing does not replace treatment by a healthcare provider.

I understand the test purpose, procedures, possible benefits and risks, and I can request a copy of this consent form. I can ask questions before I sign this consent form, and I understand I can ask additional questions at any time.

I understand there will be no out of pocket charge for the tests, the costs will be covered by my health insurance, CARES Act funding for the uninsured, and or other CARES Act funding through the State of Arizona.

I understand I can contact my child's school at any time to end my child's participation in the testing program.

Child's Name: _____ Child's Date of Birth: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Child COVID-19 Testing Registration Form

School name: _____

Grade level: _____

In Office DX

Patient/Student Information

Last name: _____ First name: _____ Middle Initial: _____

Date of Birth: _____

Health Insurance Company: _____ Policy #: _____

If no insurance, please check box: ☐

Contact/Parent/Guardian information for test results:

Name: _____

Address: _____ Apt#: _____ City: _____ Zip code: _____

Phone number: _____ Email: _____

A negative test result will be communicated by email. We will provide notification by phone and email for a positive test result.

Child COVID-19 Testing Registration Form

School name: _____

Grade level: _____

In Office DX

Patient/Student Information

Last name: _____ First name: _____ Middle Initial: _____

Date of Birth: _____

Health Insurance Company: _____ Policy #: _____

If no insurance, please check box: ☐

Contact/Parent/Guardian information for test results:

Name: _____

Address: _____ Apt#: _____ City: _____ Zip code: _____

Phone number: _____ Email: _____

A negative test result will be communicated by email. We will provide notification by phone and email for a positive test result.