Date _____

Consent to COVID-19 Test

Please carefully read and provide written acknowledgment of the following informed consent:

a. I authorize a COVID-19 testing administrator associated with the school district to conduct collection and testing for COVID-19 through a nasal swab collection as part of a school-based COVID test pilot program.

b. I authorize the test result to be disclosed to the county, state, or to any other governmental entity as may be required by law.

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

d. I give permission for the Osage County Health Department and my school district to contact me using non-secure methods (e-mail) regarding this COVID-19 test result, and I understand the risks involved.

_____ _____

Patient Name Date of Birth

_____

Printed Name of Parent/Guardian (If patient is under the age of 18)

_____

Relationship to Patient

_____

Signature (Parent/Guardian signature if patient is under the age of 18)