

CINCINNATI PUBLIC SCHOOLS COLLABORATION
in collaboration with the
Cincinnati Health Department
COVID-19 CONSENT to TESTING

If your child becomes ill with possible COVID symptoms at school, they may be offered a COVID test.

COMPLETE THIS FORM ONLY IF YOU CONSENT FOR YOUR CHILD TO GET A COVID-19 TEST AT SCHOOL IF THEY BECOME ILL

SCHOOL NAME:	Grade/HR
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PLEASE PRINT PATIENT INFORMATION

STUDENT NAME (Last Name):	(First Name):	(M.I.):	MRN/Control#
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Date of Birth:	Sex <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Other	Ethnic Group <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic	Parent/Guardian (If different than patient):
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Race: Alaskan Native AM-American Indian Asian Black/African American Native Hawaiian
 Patient Refused Unknown White

Street Address: Apt. #:	City:	State:	County	Zip Code:
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Home Phone:	Alternate/Cell Phone:	Email Address:
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Medical Card/Insurance ID #: _____
 CareSource Molina Buckeye Paramount United Health Care No Insurance OTHER _____
*** No Student will be denied a COVID-19 test due to inability to pay or lack of insurance.**

EMERGENCY CONTACT:
Name: _____ Relationship: _____ Phone Number: _____

Are we able to leave messages with your emergency contact Yes _____ No _____

Authorization and Consent for Covid-19 Diagnostic Testing: I voluntarily consent and authorize the City of Cincinnati Health Department, WinMed, Crossroad, Mercy Health, Cincinnati Children's Hospital Medical Center, and Cincinnati Public Schools, hereafter referred to as the "**CPS Collaboration**" to conduct collection, testing, and analysis for the purposes of a COVID-19 diagnostic test. I acknowledge and understand that my child's COVID-19 diagnostic test will require the collection of an appropriate sample by an authorized medical provider or public health official through a nasopharyngeal swab, oral swab, or other recommended collection procedure according to the manufacturer's stated directions. I understand that there are risks and benefits associated with undergoing a diagnostic test for COVID-19 and there may be a potential for false positive or false negative test results. I understand the testing unit is not acting as my child's medical provider, this testing does not replace treatment by my child's medical provider, and I assume complete and full responsibility to take appropriate action with regards to 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.

I understand I will receive the Cincinnati Health Department Post-Test Procedures and be offered the Cincinnati Health Department's Notice of Privacy Practices prior to my child receiving a COVID-19 diagnostic test.

Release of Testing Results: I acknowledge that my child's COVID-19 test results and associated information may be released or obtained by the CPS Collaboration for treatment or continuity of care, and by the City Health Director to release to persons or entities, including Cincinnati Public Schools, to control, prevent, or mitigate the spread of COVID-19.

Disclosure to Government Authorities: I acknowledge that my child's test results and associated information may be shared with appropriate county, state, Cincinnati Public Schools, or other governmental and regulatory entities as may be permitted by law.

Release: To the fullest extent permitted by law, I hereby release, discharge and hold harmless the **CPS Collaboration**, including, without limitation, any its respective officers, directors, employees, representatives and agents from any and all claims, liability, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to my child's COVID-19 diagnostic test or the disclosure of my child's COVID-19 test results.

I acknowledge and agree that I have read, understand, and agreed to the statements contained within this form. I have been informed about the purpose of the COVID-19 diagnostic test, procedures to be performed, potential risks and benefits, and associated costs. I have been provided an opportunity to ask questions before proceeding with a COVID-19 diagnostic test and I understand that if I do not wish to continue with the collection, testing, or analysis of a COVID-19 diagnostic test for my child, I may decline to receive continued services. I have read the contents of this form in its entirety and voluntarily consent to undergo diagnostic testing for COVID-19.

Parent/Legal Guardian Signature: _____ Date: _____

Print Name of Parent/Legal Guardian: _____ Cell Phone Number: _____

CHILD'S PRIMARY CARE PROVIDER:

Name: _____

Address: _____

Phone: _____

Date of Test: _____

Health Partner: _____

Test Result _____

Provider Name: _____

Type of Test: _____