|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **[School or Child Care Facility Name] Teacher/Staff Information** | | | | | | | |
| **Last Name**: | | **First Name:** | | | **Middle Name:** | | **Birth Date:**  \_\_/ /\_\_\_ |
| **Address**:  **(Not a PO Box)** | **Street:**  **City:** **State:** **Zip:** | | | | | | |
| **Phone Number:** |  | **Email:** |  |  | | **Gender:** ☐M ☐F  ☐ Other  ☐ Prefer not to answer | |
| **Race:** | * American Indian/Alaskan Native ☐Asian ☐Black or African American * Hawaiian Native or Other Pacific Islander ☐White ☐Not Stated | | | | | **Hispanic/Latino:**  ☐Yes ☐No ☐Unknown | |

**By completing and submitting this form, I authorize the administration of a COVID-19 antigen test on me during school or child care hours or while participating in a school or child care-sponsored activity. I understand that authorizing a COVID-19 test is optional and that I can refuse to give this authorization, in which case, I will not be tested. I further understand that I must stay home if feeling unwell prior to the school day.**

**Consent and Data Sharing (please initial):**

\_\_\_\_\_ In the event I show symptoms of COVID-19, I authorize the administration of a COVID-19 antigen test on me. I understand that my test results will be reported to me and to the Virginia Department of Health, in accordance with state law.

\_\_\_\_ In the event I am exposed to a known positive case of COVID-19, I authorize the administration of a COVID-19 antigen test to be used on me. I understand that my test results will be reported to me and to the Virginia Department of Health, in accordance with state law.

**Authorized Signatory:**

I understand that I can change my mind and cancel this permission at any time. To cancel this permission for COVID-19 testing, I need to contact [POC Name] directly at [Contact Info].

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Signature of Staff Member Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Printed Name