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| **[School or Child Care Facility Name] Student Information** |
| **Last Name**: | **First Name:** | **Middle Name:** | **Birth Date:** / /  |
| **Address**:**(Not a PO Box)** | **Street:**  **City:** **State:** **Zip:**  |
| **Parent phone:** |  | **Parent 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 confirm that I am the appropriate parent / legal guardian to provide consent, and that I authorize the administration of a COVID-19 antigen test on my student during school or child care facility hours or while participating in a school or child care facility-sponsored activity. I understand that authorizing a COVID-19 test for my student is optional and that I can refuse to give this authorization, in which case, my student will not be tested. I further understand that my student must stay home if feeling unwell prior to the school day.**

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

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

\_\_\_\_ In the event my student is exposed to a known positive case of COVID-19, I authorize the administration of a COVID-19 antigen test on my student. I understand that my student’s 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 Student, Parent/Guardian Name Relationship to Patient

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Printed Name Date