

Pawnee CUSD #11

COVID-19 Testing Consent Form

DEMOGRAPHIC INFORMATION

Student Staff **SCHOOL:** Grade School JR High HS

Name: _____ **DOB:** _____

Parent Name: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

SEX: Male Female Other Unknown

ETHNICITY: Hispanic Not Hispanic Unknown

RACE: American Indian or Alaska Native Black or African American

White Unknown

Asian Native Hawaiian/ Other Pacific Islander

Other Race/Multiracial

The law requires and/or allows some information to be shared with the Sangamon Department of Public Health (SCDPH) and the Illinois Department of Public Health (IDPH). This includes notifying about the COVID-19 results and can include the name, date of birth, parent name and phone number of the individual tested.

- I authorize Pawnee School District to test the above named for COVID-19 infection
- I understand that the above listed may be tested multiple times during the 2021-2022 school year
- I authorize the above named test results and other information to be disclosed to any government entity as may be required or permitted by law
- I acknowledge that a positive test result will require the above named and any other household members to be sent home from school and remain at home until he/she meets the criteria to return according to SCDPH
- I understand that this testing dose not replace treatment by the above named medical provider. I assume complete and full responsibility to take appropriate action regarding the test results. I agree that I will seek medical advice, care and treatment for the above named from his/her medical provider if I have questions, concerns or if condition worsens.
- I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.
- I have read this information and have signed this form freely and voluntarily.
- I am legally authorized to make decisions for the above named.

Please choose option below:

- Yes, I agree and give my consent for the above named to be tested
- No, I do not agree and DO NOT give consent for the above named to be tested

Signature: _____ **Date:** _____

Please contact Jodi Anderson, RN at 217-625-2231 ext 203 with any questions.