COVID-19 Testing Consent

Authorizing Provider:	Testing Site:
Nasopharyngeal Nasal Type of Test:	Lab Assigned:

Minor's Information

Minor's Name (Last, First Middle)	Minor's DOB (MM/DD/YYYY)
Preferred Parent/Guardian Phone Number	Minor's Address

I authorize that a test sample be taken for COVID-19 by Capital Diagnostics at the McLean School. By signing below, I authorize Capital Diagnostics to verify my insurance benefits and submit my claim to insurance or the HRSA Covid fund in case I do not have insurance. I understand I am responsible for patient responsibility indicated by my insurance carrier which is not otherwise covered by my carrier at Medicare rates. I do hereby consent to any physician or health care provider or authorized provider examining or testing my minor child to use or disclose protected health information for reporting purposes.
I authorize my child's test results to be released to The McLean School.

SECTION BELOW TO BE COMPLETED BY PARENT/GUARDIAN FOR CHILD UNDER 18

I, _____, have the following relationship with the person above:

Father Mother Stepfather Stepmother Court ordered legal guardian
Grandfather Grandmother Adult Aunt Adult Uncle Adult Brother Adult Sister

I have the legal authority, based on the relationship to the child as indicated above pursuant to s. 743.0645, F.S., to consent to this test administration for the child named above.

Parent or Guardian Signature	Date