COVID-19 Consent to Test

Please carefully read and provide written acknowledgement of the following informed consent:

1. I authorize a COVID-19 testing administrator associated with the school district, local health department or state health department to conduct collection and testing for COVID-19 through a saliva sample, nasal or nasopharyngeal swab collection as ordered by an authorized medical provider or public health official.

2. I authorize my test result, or the test result of my child if my child is under the age of 18 years, to be disclosed to the county, state, or to any other governmental entity as may be required by law.

3. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

4. I give permission for the KIOWA COUNTY HEALTH DEPARTMENT and my school district to contact me using non-secure methods (e-mail) regarding this COVID-19 test result, and I understand the risks involved.

_____ _____

Signature of client or parent (if client is under age 18) Date of Birth (parent if client a minor)

_____

Date