PARENT/STUDENT CONSENT FORM

Abbott BinaxNOW Antigen Test and SARS-CoV-2 molecular (PCR) Test
Sample Parent/Guardian Authorization for Minors

By completing and submitting this form, I confirm that I am the appropriate parent / guardian to provide consent, and that I authorize the administration of a COVID-19 antigen test or PCR test on my student or minor staff member upon initial arrival to school, if school staff observe symptoms consistent with COVID-19 or isolated symptoms (e.g., isolated runny nose, isolated headache, or isolated abdominal pain without fever), or if the school is conducting periodic COVID-19 surveillance testing. I understand that such testing is optional, and I can refuse to give this authorization, in which case, my student/minor will not be tested but may not be permitted to stay in school without medical documentation.

Student/Minor Staff Demographic Information:
First Name: _____

Last Name: _____

Middle Name: _____

Address (street, city, zip code): _____

_____

Date of birth? _____

What is the Student/Minor staff's race? (Select all that apply):
____ American Indian/Alaskan Native
____ Asian
____ Black/African American
____ Native Hawaiian/Pacific Islander
____ White
____ Other
____ Unknown

Is the Student/Minor of Hispanic origin? (Select one):
____ Yes
____ No
____ Unknown

What is the Student/Minor gender? (Select one):
____ Male
____ Female
____ Unknown

Is the Student/Minor transgender?
___ Yes
____ No

Does the Student/Minor have a disability? (Select one):
____ Yes
____ No

What is the Student/Minor's primary language?
_____

Parent/Guardian Information:
Parent/Guardian First Name: _____

Parent/Guardian Last Name: _____

Parent/Guardian Address (if different than above): _____
_____

Parent/Guardian Phone Number: _____

Parent/Guardian Email Address: _____

Consent and Data Sharing (please initial):

_____ Upon initial arrival to school, in the event my Student/Minor shows symptoms of COVID-19, or if the school is conducting periodic COVID-19 surveillance testing, I authorize school staff to administer the Abbott BinaxNOW COVID-19 antigen test on my Student/Minor. I understand that their test results will be shared with the Illinois Department of Public Health in accordance with state law.

_____ I authorize the disclosure of my contact information to IDPH.

Authorized Signatory:
I understand that I can change my mind and cancel this permission at any time, but that such cancellation is forward-looking only, and will not affect information I already permitted to be released. To cancel this permission for COVID-19 testing, I need to contact school staff directly.

_____
Parent/Guardian Name (Print)

_____ _____
Parent/Guardian Signature Date