COLUMBUS CITY SCHOOLS

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.®

Columbus City Schools partnering with Nationwide Children's Hospital

COVID-19 CONSENT to TESTING

If your child is ill at school with possible COVID symptoms, they may be able to get a COVID test.

FILL IN THIS FORM ONLY IF YOU WILL ALLOW YOUR CHILD TO GET A COVID-19 TEST AT SCHOOL IF THEY ARE ILL

SCHOOL NAME:	**Grade/HR**

PLEASE PRINT PATIENT INFORMATION

STUDENT NAME (Last Name):	(First Name):	(M.I.):	**MRN#**

Date of Birth:	Sex ◯ Male ◯ Female ◯ Other	Ethnic Group ◯ Hispanic ◯ Non-Hispanic	Parent/Guardian (If different than patient):

Race: ◯ Alaskan Native ◯ AM-American Indian ◯ Asian ◯ Black/African American ◯ Native Hawaiian ◯ Prefer Not To Disclose ◯ Unknown ◯ White

Street Address: Apt. #:	City:	State:	County	Zip Code:

Home Phone:	Other/Cell Phone:	Email Address:

Medical Card/Insurance ID #: _____

◯ CareSource ◯ Molina ◯ Buckeye ◯ Paramount ◯ United Health Care ◯ No Insurance ◯ OTHER _____

*** No Student will be denied a COVID-19 test due to inability to pay or lack of insurance.**

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone Number: _____

Are we able to leave messages with your emergency contact Yes _____ No _____

Authorization and Consent for Covid-19 Diagnostic Testing: I voluntarily consent and allow Columbus City Schools and Nationwide Children's Hospital, hereafter referred to as the "**CCS Collaboration**", to collect, test, and analyze for the purposes of a COVID-19 diagnostic test. I accept and understand that my child's test to diagnose COVID-19 will require the CCS Collaborative to collect an appropriate sample. This will be done by a CCS School Nurse through a nasopharyngeal (nose) swab, oral (mouth) swab, or other recommended collection procedure based on the manufacturer's stated directions. I understand that there are risks and benefits related to having a diagnostic test for COVID-19. There can be false positive or false negative test results (test results that are not correct). I understand the testing unit is not acting as my child's healthcare provider. This testing does not replace treatment by my child's healthcare provider. I assume complete and full responsibility to take the correct action with regards to my child's test results. I agree I will seek medical advice, care and treatment from my child's healthcare provider if I have questions or concerns, or if my child's illness becomes worse. I understand I will be offered the Nationwide Children's Hospital COVID 19 Helping Hand™ (patient education handout), and the Notice of Privacy Practices before my child gets a COVID-19 diagnostic test. Any questions I have about the COVID-19 testing can be answered by any of (1) a Columbus City Schools School Nurse, (2) the Nationwide Children's School Health team that you can call at 614-355-2590, or (3) the Nationwide Children' Patient/Family Covid Line you can call at 614-722-2787.

Release of Testing Results: I acknowledge that my child's COVID-19 test results and related information may be released or obtained by the CCS Collaboration for treatment, continued care, and, to control, prevent, or reduce the spread of COVID-19.

Disclosure to Government Authorities: I acknowledge that my child's test results, and related information may be shared with appropriate county, state, Columbus City Schools, or other governmental and regulatory entities as may be permitted by law.

Release: To the fullest extent permitted by law, I hereby release, discharge and hold harmless the **CCS Collaboration**, including, without limits, any of its respective officers, directors, employees, representatives and agents from any and all claims, liability, and damages, of whatever kind or nature, arising out of or connected with any act or omission relating to my child's COVID-19 diagnostic test or the reporting of my child's COVID-19 test results.

I acknowledge and agree that I have read, understand, and agreed to all statements in this form and consent to the testing to diagnose COVID-19. I have been informed about the purpose of the test to diagnose COVID-19, procedures to be done possible risks and benefits, and any costs. I have been given a chance to ask questions before having my child get the COVID-19 diagnostic test. I understand that if I do not wish to continue with the collection, testing, or analysis of a COVID-19 diagnostic test for my child, I may decline to continue services.

Parent/Legal Guardian Signature: _____ Date: _____
Time: _____

Print Name of Parent/Legal Guardian:_____ Cell Phone Number: _____

CHILD'S PRIMARY CARE PROVIDER:
Name: _____
Address: _____
Phone: _____

Date of Test: _____
Test Result_____ **Type of Test:** _____