COVID-19 TESTING CONSENT

Last Name, First Name	Date of Birth	Grade	Street Address

I authorize that a test sample be taken for COVID-19 as ordered by the authorizing provider. I understand that the law allows that the results of this testing be shared with New York State Health Departments.

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

I, _____, am the parent or legal guardian for the above student(s). I have the legal authority, based on my relationship to the child(ren) above to consent to this test administration for the child(ren) named above. I understand that the law allows some information to be shared for public health purposes. I understand that this permission will remain in effect until my child(ren) either leaves the Dryden Central School District or until I notify my child(ren)'s School Nurse, in writing, that I withdraw this permission.

Parent or Guardian Signature	Date

COVID-19 Testing Consent
LAB USE ONLY

Authorizing Provider: : Dr. Donna Pierre, MD	Testing Site: DCSD
Nasal Swab Type of Test: Abbot BinaxNOW Ag Card	 Lab Assigned: DCSD