PEARL
DIAGNOSTIC LABORATORY

COVID Testing Consent Form
Informed Consent for Coronavirus (COVID-19) Screening

I, Parent/Legal Guardian of [Insert Student Name]_____ authorize Pearl Medical and Diagnostic Laboratory to conduct collection, testing, and screening for COVID-19 using a Rapid Antigen test and/or a RT-PCR test. I acknowledge that this screening is being conducted in the [Insert School] _____ at my request and any results or findings are for its benefit in order to determine whether it is safe for [Insert Student Name]_____ to attend school. I further acknowledge and expressly consent to each of the following:

1. I authorize my child's test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
2. I acknowledge that a positive test result is an indication that my child must self-isolate in an effort to avoid infecting others.
3. I understand that my child is not creating a patient relationship with Pearl Medical and Diagnostic Laboratory by participating in this screening. I further understand that Pearl Medical and Diagnostic Laboratory is not acting as my child's medical provider.
4. I understand that testing does not replace treatment by my child's medical provider. I assume complete and full responsibility to take appropriate action with regards to my child's test results. I agree that I will seek medical advice, diagnosis, care, and any necessary treatment from a medical provider for my child if I have questions or concerns, or if my child's condition requires me to do so. If my child does not have a medical provider, I may ask Pearl Medical and Diagnostic Laboratory for a list of health care professionals from whom my child may receive follow-up care.
5. I understand that, as with any medical test, there is the potential for the occurrence of a false positive or false negative test result. These tests do not exclude the possibility of other infectious diseases.
6. I understand my results will be provided to the School(s) and the DPH (Department of Public Health).
7. I understand the risks of unencrypted email and do hereby give permission to the Pearl Medical to send personal health information via unencrypted contact email address.

I have been given the opportunity to ask questions about this Consent before I sign, and I have been told that I can ask other questions at any time.

Faculty / Student's Name: _____ Grade: _____

Parent/Guardian Name (please print): _____ Parent/Guardian Signature: _____

Check if applicable: Faculty ( ) Parent ( ) Guardian ( ) Legally Authorized ( )
Date Signed: _____

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