

**COVID-19 TEST DURATION CONSENT**

**Student ID#:** \_\_\_\_\_

**Student Info**

Student First Name \_\_\_\_\_

Student Last Name \_\_\_\_\_

Student Birth Date \_\_\_\_\_

Student Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Email \_\_\_\_\_

Gender  Female  Male  Decline to Specify  
 Hispanic or Latino  Non-Hispanic or Latino  
 Decline to Specify

Ethnicity  Other \_\_\_\_\_  
 Asian  Asian Indian  African American  
 American Indian  Caucasian (white)

Race  Other  Decline to Specify

**If Patient is under 18 years old:**

Guardian First Name \_\_\_\_\_

Guardian Last Name \_\_\_\_\_

Guardian Cell Phone \_\_\_\_\_ Guardian Home number \_\_\_\_\_

Guardian Email \_\_\_\_\_

May we email you?  Yes  No

May we text you?  Yes  No

**COVID-19 TEST DURATION CONSENT**

**Student ID#:** \_\_\_\_\_



**Medical History**       Diabetes     High Blood Pressure     Asthma     Other

If other, please explain: \_\_\_\_\_

**Allergies (List):** \_\_\_\_\_

By signing this form, you are consenting for COVID-19 weekly testing until June 30, 2022. If you feel ill, you should seek medical attention as soon as possible. You consent that the information on this form is accurate and okay to receive results via email or text. I understand this test does not confirm a medical evaluation. You authorize JL Hudson Holdings LLC, SaintJames Health, Inc. or its assignee to bill your insurance/health coverage for these services; when available. You authorize us to release any information/medical records for billing and reimbursement to state/county authorities as required by state guidelines. If your insurance company pays you directly for our services, you agree to endorse that payment to us within 15 days of receipt. You consent to allowing JL Hudson Holdings LLC or Saint James Health, Inc. to share your results with Newark Public Schools.

\_\_\_\_\_

**Signature**

**Date**

Please specify relationship to Minor:

Parent with Legal Custody     Guardian with Legal Custody

**PRIMARY INSURANCE**

**Insurance Company:** \_\_\_\_\_

**Member ID:** \_\_\_\_\_

**Group ID:** \_\_\_\_\_

Self       Spouse       Child

**Relationship to Insured:**  Other: \_\_\_\_\_

**Name of Policy Holder** \_\_\_\_\_ **Policy Holder Date of Birth:** \_\_\_\_\_

**Policy Holder Address:** \_\_\_\_\_

**COVID-19 TEST DURATION CONSENT**

**Student ID#:** \_\_\_\_\_

**SECONDARY INSURANCE**

**Insurance Company:** \_\_\_\_\_

**Member ID:** \_\_\_\_\_

**Group ID:** \_\_\_\_\_

**Self**       **Spouse**       **Child**

**Relationship to Insured:**  **Other:** \_\_\_\_\_

**Name of Policy Holder** \_\_\_\_\_ **Policy Holder**  
**Date of Birth:** \_\_\_\_\_

**Policy Holder Address:** \_\_\_\_\_

**NO INSURANCE**

I, \_\_\_\_\_, attest that I am

uninsured effective of \_\_\_\_/\_\_\_\_/\_\_\_\_

**Social Security Number:** \_\_\_\_\_

I affirm that all information given on this attestation is true, complete, and accurate to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date