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

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to Specify

Race ☐ Other _____ ☐ Asian ☐ Asian Indian ☐ African American ☐ American Indian ☐ Caucasian (white) ☐ 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: _____

Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **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: _____

Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **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