

COVID-19 Testing Consent

Authorizing Provider: <input type="radio"/> Nasopharyngeal <input type="radio"/> Oral <input type="radio"/> Mid-turbinate	Testing Site: Lab Assigned:
Type of Test:	Lab Assigned:

Minor's Information

Minor's Name (Last, First Middle)	Minor's DOB (MM/DD/YYYY)
Preferred Parent/Guardian Phone Number	Minor's Address

I authorize that a test sample be taken for COVID-19 as ordered by the authorizing provider (or my child's or legal dependent's physician or authorized healthcare provider). I do hereby consent to any physician or health care provider or authorized provider examining or testing my minor child to use or disclose protected health information for reporting purposes.

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

I, _____, have the following relationship with the person above:

- Father
 Mother
 Stepfather
 Stepmother
 Court ordered legal guardian
 Grandfather
 Grandmother
 Adult Aunt
 Adult Uncle
 Adult Brother
 Adult Sister

I have the legal authority, based on the relationship to the child as indicated above pursuant to s. 743.0645, F.S., to consent to this test administration for the child named above.

Parent or Guardian Signature	Date
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