COVID-19 Testing Consent

Authorizing Provider: Robert Van Amerongen MD	Testing Site: The Waldorf School of Garden City
X Nasopharyngeal ◯ Oral ◯ Mid-turbinate Type of Test: Swab	Lab Assigned: Genesis

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 New York Public Health Law § 2504, to consent to this test administration for the child named above.

Parent or Guardian Signature	Date