COVID-19 Consent Explanation

Appendix H

Dear Parents/Guardians,

We here at the Child & Adolescent Health Center (CAHC) are committed to providing the best and safest health care available for your child. With the COVID-19 global pandemic in full swing, we want to offer you the services of the CAHC to evaluate and/or test your child for COVID-19 should he/she develop symptoms while attending school.

We are offering this service only if you sign the provided "Consent for COVID-19, Medical evaluation and Testing by the CAHC" form. By signing this form, you are giving us permission to evaluate and/or test your child. We will not see your child for any other reason unless your child is already enrolled in our center.

We cannot see your child for this service unless this form is completed and signed by you, the parent/guardian. You will receive a phone call from our staff telling you we saw your child and whether or not we tested him/her for COVID-19.

Again, the staff here at the Child & Adolescent Health Center is committed to the health and safety of not only your child/children but all the children in our community.

FAMILY HEALTH CARE
Child & Adolescent Health Center
WHITE CLOUD

Consent for COVID-19, Medical evaluation and Testing by the CAHC

By signing this consent, I affirm I am the legal parent/guardian of

Name: _____ Date of Birth: _____ Sex: _____

Address: _____

Mailing Address: _____

Primary Care Provider: _____

Allergies: _____

I give my permission for him/her to be evaluated by a medical provider and tested for COVID-19 at the Child & Adolescent Health Center located in the school. This will occur if my child displays signs or symptoms of COVID-19 or has had recent contact with a person who has tested positive for COVID.

Please supply 2 phone numbers where you can be reached:

1) _____ 2)_____

EMERGENCY CONTACT: _____

Signature: _____

Printed name: _____ Date: _____

_____ _____ Policy#_____

Primary Insurance Company Name of Insured Group#_____

_____

Address/Street

_____ _____

City State Zip MEDICAID/MEDICARE #

Residing in the White Cloud School District at 555 E. Wilcox Street, White Cloud, MI 49349
Phone: (231) 689-3268 • Fax: (231) 689-1030