

East Side Health District
638 N. 20th Street
East St. Louis, IL 62205

EAST SIDE HEALTH DISTRICT

Test To Stay CONSENT

_____ can participate in **Test To Stay**. I give consent to allow
Student Full Name
the **East Side Health District** employees to perform a BinaxNow Rapid Covid test. This test will allow the student to continue educational learning at school. Any consequences and the nature of this procedure will be explained to you if your student qualifies.

East Side Health District will perform this test on days 1, 3, 5, and 7 after exposure.

First & Last Name (PRINT)

Signature

Date

Relation To Student

- Parent Minor
- Power Of Attorney
- Guardian
- Other _____

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FOR STAFF USE ONLY

I attempted to obtain an Acknowledgement of the Receipt of the Notice of Privacy Practices on behalf of the ESHD. The ESHD was unable to obtain the Acknowledgement because:

- Client refuses to sign
- Other (Specify) _____

_____ (Staff Member Initials)

_____ (Date)

(Staff: Place Acknowledgement in patient's medical record.)