CAMPBELL COUNTY SCHOOLS CONSENT TO TREAT

COVID -19 TESTING

I voluntarily give my consent for my child/children to be tested for COVID-19 as needed in the school setting. I give authorization for trained CCS nurses to provide this test. I understand this consent will remain valid throughout the 2022-2023 academic year unless revoked by me. **I may revoke this consent for treatment at any time by requesting in writing that the district remove my child's name from this service.** I understand I will be contacted by a CCS representative prior to any testing performed and testing will only be performed if mutually agreed upon by parent/guardian and CCS Nurse.

Student Name: ____ Grade: ______

Student Name: ____ Grade: ______

Student Name: ____ Grade: ______

Parent/Guardian Name: ____

Relationship to Student: ____________________________

Parent/Guardian Signature____

Date: _________________