Children's Medical Group, PA

Specimen Collection Form

Section A: Demographic Information

NAME (Last)	(First)	(M.I.)
MAILING ADDRESS		
CITY	STATE	ZIP
DATE OF BIRTH _____/_____/_____ Month / Day / Year	PHONE NUMBER	
LOCATION OF CLINIC/SPECIMEN COLLECTION:		

INSURANCE TYPE	POLICY NUMBER	GROUP NUMBER
POLICY HOLDER'S NAME	POLICY HOLDER'S DOB	

INFORMED CONSENT FOR COVID-19 TESTING

Name: **DOB:**

Please carefully read the following informed consent:

1. I authorize Children's Medical Group. PA and/or an independent laboratory acting on Children's Medical Group. PA behalf to conduct collection and/or testing for Covid-19 through a nasopharyngeal swab [or other method], as ordered by an authorized medical provider or public health official.

2. I authorize my test results to be disclosed to Children's Medical Group. PA and to any applicable county, state, or other governmental entity as may be required by law, and understand that such disclosure will also be made consistent with applicable law.

3. I acknowledge that a positive test result is an indication that I must abide by Children's Medical Group. PA isolation and quarantine policies and all applicable federal, state and/or local guidance on isolation and quarantine to avoid infecting others.

4. I understand that by signing this document and agreeing to undergo Covid-19 testing that I am not creating a patient relationship with Employer. I understand that Children's Medical Group. PA is not acting as my medical provider. Testing does not replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.

5. I understand that, as with any medical test, there is the potential for false positive or false negative test results to occur.

6. By signing this form, I acknowledge that I have received a copy of Children's Medical Group. PA Notice of Privacy Practices.

ACCEPTANCE

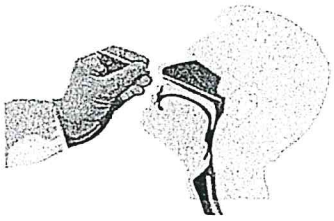
I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this informed consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I agree to testing for Covid-19. I understand my medical insurance will be billed for the Covid-19 testing.

Signature: _____ **Date:** _____

DECLINATION

I decline COVID-19 testing at this time. [Employer] has reviewed, and I understand, potential risks of not participating in baseline testing and that declining testing may affect my ability to work until I am tested.

Signature: _____ **Date:** _____



Section B: Information about Specimen Collection & Consent

For initial diagnostic testing for SARS-CoV-2, CDC recommends collecting and testing an upper respiratory specimen. Children's Medical Group, PA is currently doing nasopharyngeal (NP) specimen collection. A NP swab is collected by inserting a minitip swab with a flexible shaft (wire or plastic) through the nostril parallel to the palate (mouth), not upwards, until resistance is encountered or the distance is equivalent to that from the ear to the nostril of the patient, indicating contact with the nasopharynx. Swab should reach depth equal to distance from nostrils to outer opening of the ear. Gently rub and roll the swab. Leave swab in place for several seconds to absorb secretions. Slowly remove swab while rotating it. Specimens can be collected from both sides using the same swab.

I have reviewed the information on how a nasopharyngeal swab is performed and have had the opportunity to ask questions. I give my consent for the Children's Medical Group, PA to perform specimen collection and subsequent testing of that specimen for COVID-19.

Name: _____

Signature: _____ **Date:** ___/___/_____

If Individual to be tested is under 18 years of age:

Name of Parent/Legal Guardian:

_____

*If minor is in state custody, an authorized representative signature is required.

Parent/Legal Guardian Signature:

_____ **Date:** ___/___/___

*If minor is in state custody, an authorized representative signature is required.

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Name, Title and Signature of Healthcare Professional Collecting Specimen:

_____ _____

Name (Print) Title/Credentials

_____ Date: ___/___/___

Signature