COVID-19 TEST DURATION CONSENT

Today's Date :______/______/______Please attach a copy of your **insurance card (if applicable)** and **ID** to this application.

Patient Full Name: ____

Patient Address: ____
City:________________ State:_______ Zip Code: ___________

Patient Date of Birth:______/______/______Student ID#: __________________

Parent/ Guardian Name **(if Patient is under 18 years old):_____________________________**

Phone Number:____________________Is this a Cell Number?____ Yes___No
May we text you on this number?_____ Yes_____No

Email:____________________________________@_________________
May we Email you?_____ Yes_____No

Did you schedule an Appointment Online through the portal:____ Yes_____No
If Yes, What was your Appointment Time: ____________

Are you an Existing Patient:____ Yes___No

Medical History:____ Diabetes___High Blood Pressure___Asthma____Other: **If Other, Please Explain:**____
Medical Allergies:____

Test Reason:____ School/ Work Requirement : **School Name:**_________________
____ Hybrid _____Fulltime Remote Grade:_____________

By signing this form, you are consenting for COVID-19 weekly testing until August 31, 2022. If you feel ill, you should seek medical attention as soon as possible. You consent that the information on this form is accurate and okay to receive results via email or text. I understand this test does not confirm a medical evaluation. You authorize JL Hudson Holdings LLC or its assignee to bill your insurance/health coverage for these services; when available. You authorize us to release any information/medical records for billing and reimbursement to state/county authorities as required by state guidelines. If your insurance company pays you directly for our services, you agree to endorse that payment to us within 15 days of receipt. You consent to allowing JL Hudson Holdings LLC to share your results with Orange Township Public Schools.

X Parent/Guardian/Patient Signature: _________________________________

Office Notes: _________