



## PARENT/GUARDIAN CONSENT FORM FOR WEEKLY STUDENT COVID TESTING

I hereby acknowledge full and complete consent to and make a request for Covid Testing for my child while they are a student of *St. Paul the Apostle School* through August 2021/2022. I hereby request and authorize PMH Laboratory, Inc. designated subcontractor who is an independent nurse/healthcare staffing agency, not directly affiliated with PMH Laboratory, Inc., to collect this sample for the person named.

below for whom I am the legal guardian, I hereby release *St. Paul the Apostle School* and The PMH Laboratory, Inc. from all liability. I understand that this testing is voluntary and that I have the option to get weekly testing for my child on my own. I also understand that the results of the Covid testing will only be shared with the necessary *St. Paul the Apostle School* Administrators/Support Staff and will only be used for the purposes of my child's attendance at *St. Paul the Apostle School* .

The PMH Laboratory, Inc., is not providing you with medical advice nor are they responsible for any testing outcome.

CHILD'S NAME (*Please print*): \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_