PATIENT LABEL
(without MR #)

Consent for Minors COVID-19 Rapid Test Prior to Admission

Name of Minor Being Tested:________________________________ DOB:________
(Please Print)

Minor's Address:____
City State Zip

Name of Parent/Guardian:___________________________________

Address of Parent/Guardian: ____
(write same if it is the same as the minor's address) City State Zip

Cell Phone Number of Parent/Guardian (Required): ______________________________

Email Address of Parent/Guardian (Required):__________________________________

Four Winds Hospital does not provide emergency psychiatric care and admissions are by appointment only. When you scheduled your appointment you were advised that in order to prevent the spread of the coronavirus and to protect the patients currently in the hospital, a condition of admission is a negative result of a COVID-19 test. You have been offered the opportunity to obtain a test from another health care provider instead of having the test conducted at the hospital prior to admission.

Your child/ward will receive a free BD Rapid Antigen Test to detect the COVID-19 virus. Collecting a specimen for testing involves inserting a small swab, similar to a Q-Tip, into the front of the nose. There may be some minor discomfort in the nose or throat or bleeding in the nose. You will be given the results of the test in writing.

You acknowledge that you have been advised that if your child/ward tests positive:

- a psychiatric assessment of your child/ward will not be conducted
- the hospital will not be able to proceed with the admission
- you will be asked to leave hospital grounds
- you will be referred back to your child/ward's outpatient mental health provider and given a list of Crisis Resources and Emergency Rooms
- your outpatient mental health provider will be contacted and told that the admission was not able to proceed due to a positive result from a COVID-19 rapid test

By signing below, I attest that:

- I have signed this form freely and voluntarily and I am legally authorized to make decisions for the child named above.
- I consent for my child/ward to be tested for COVID-19 infection.
- I understand that tests sometimes produce incorrect results and that the result of this test is it not a guaranteed that my child/ward does not have COVID-19 at this time.
- I understand that my child/ward's test results may be disclosed as required by law.
- I consent to the disclosure of my child/ward's positive test results to my child/ward's outpatient behavioral health and medical providers.

____ ____________
Signature of Parent/Guardian Date

Witness Print Name: __________________________________

Witness Signature: ___________________________________