



CONSENT/REFUSAL FORM

COVID-19 screening at school

PLEASE COMPLETE ALL SHADED SECTIONS OF THIS FORM

1. General information

Last name of the child

First name of the child

Health Insurance Card number

Expiration (year/month)

Date of birth (day/month/year)

Gender

M

F

Address (N°, street)

Municipality

Postal Code

2. Additional information

First and last name (parent 1)

First and last name (parent 2)

School

Teacher's name and the group's identification number

3. COVID-19 screening at school

By allowing your child to participate in COVID-19 screening at school, you also agree to the following:

- Your child will receive a free rapid COVID-19 detection test when exhibiting symptoms during the day;
- A worker trained by the public health department will take a nasal swab of your child for testing when this is required;
- The test results will be kept confidential at the school, your region's public health office, and the Ministère de la Santé et des Services sociaux du Québec's Direction générale de la santé publique.

4. Consent or refusal

I acknowledge having read the information leaflet for parents on COVID-19 screening at school and the information on the protection of personal information. I understand that I am free to allow my child to participate in COVID-19 screening at school or not.

I CONSENT to my child receiving screening tests for COVID-19 at school.

I DO NOT CONSENT to my child receiving screening tests for COVID-19 at school.

First and last name of parent or guardian in block letters

Telephone numbers of parent or guardian

Home

Office

Cel

Signature of parent or guardian

Date (day/month/year)