Abbott BinaxNOW Antigen Test for students and staff
Parent/Guardian Authorization for Student

By completing and submitting this form, I confirm that I am the appropriate parent / guardian to provide consent, and that I authorize the administration of a COVID-19 antigen test on my student during school hours, should school staff observe symptoms consistent with COVID-19 or isolated symptoms (e.g., isolated runny nose, isolated headache, or isolated abdominal pain without fever). I understand that authorizing a COVID-19 test for my student is optional and that I can refuse to give this authorization, in which case, my student will not be tested. I further understand that my student **must** stay home if feeling unwell.

Student Demographic Information:
Student's First Name: ____

Student's Last Name: ____

Student's Middle Name: ____

Student's address (street, city, zip code): ____

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What is the student's date of birth? ____

Parent/Guardian Information:
Parent/Guardian First Name: ____

Parent/Guardian Last Name: ____

Parent/Guardian Address (if different than above): _______________________________________
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Parent/Guardian Phone Number: ____

Parent/Guardian Email Address: ____

Authorized Signatory:
I understand that I can change my mind and cancel this permission at any time, but that such cancellation is forward-looking only, and will not affect information I already permitted to be released. To cancel this permission for COVID-19 testing, I need to contact Project Beacon directly at (617) 741-7310.

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Parent/Guardian Name (Print)

____ ______________________
Parent/Guardian Signature Date