

CONSENT TO TREAT MINOR CHILDREN

North Little Rock School District (NLRSD) is now offering testing for your child if they present with certain symptoms of an illness while at school. This is being offered to keep our students healthy and in school while reducing the spread of multiple contagious illnesses such as influenza, strep throat just to name a few. The test only requires that a nasal swab be taken and sent to the laboratory to test the swab only for the organisms that cause contagious illnesses common to school-aged children.

Before any nasal swab is taken, the need for the test will be signed off on by the school's clinician. The results of the test will be sent back to the school nurse usually within thirty-six to forty-eight (36-48) business hours of the lab receiving the sample (most often within the same day) and the school will provide a copy of the results to you for your records. No payment for the test will be required at the time of testing. The student's insurance will be billed and no financial hardship will be placed on the student/family for this testing.

NLRSD has chosen to partner with Natural State Laboratories (NSL) and its affiliate GeneX Laboratory Professional Corporation which provides a method of testing the swab sample that is more accurate than other methods used. With this information, the clinician will know how to better treat your child (e.g. antibiotic, increased monitoring, supportive care). There are many benefits to understanding what type of infection your child has including helping to prevent the spread of infection to others.

I, _____, parent or legal guardian of _____, born _____
the ____ day of _____, 20____ do hereby consent to the school clinician taking a
nasal swab and sending it out to a licensed laboratory for testing for respiratory infections as the school
clinician determined to be necessary for the welfare of my child while my child is enrolled in NLRSD, City
of North Little Rock, State of Arkansas, and I am not reasonably available by telephone to give consent.
This authorization is effective from the date of signature through the last academic school day of the
2019-2020 NLRSD school year.

Signature of Parent or Legal Guardian

Date

Witness Signature

Witness Name (please print)

This form should be taken with the child to the hospital or physician's office when the child is taken for treatment. The information below will assist in treatment if it can be furnished with the consent but is not required.

Family Address _____

Father's Telephone: _____ Mother's Telephone: _____

Last Tetanus: _____ Allergies to drugs or foods: _____

Special Medications, Blood Type or Pertinent Information: _____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy # _____

Preferred Hospital: _____