Consent and Registration Form for Rapid COVID-19 Antigen Test

Testing Facility: Holton Middle and High School

Address: 6477 Syers Road
Holton, MI 49425
Phone: (231) 821-1725 Organization: Holton Public Schools

Testing Date: April 12, 2021 (weekly thereafter)

Personal Information
First Name: _____ Last Name: _____ Middle: _____
Phone Number: ( ) - _____ - _____ Email Address: _____
DOB: (mm/dd/yyyy) ____ /____ / _____ Biological Sex: * Male * Female * Prefer not to answer
Street Address: _____
City/State/Zip: _____

Race: Please check the box next to the one that best describes your race.

- ☐ American Indian/Alaskan Native
- ☐ Black/African American
- ☐ Asian
- ☐ White/Caucasian
- ☐ Hawaiian/ Pacific Islander
- ☐ Other
- ☐ Unknown

Hispanic or Latino: Please check the box next to one of the following that best describes your ethnicity.

- ☐ Latino or Hispanic
- ☐ Not Latino or Hispanic
- ☐ Unknown or Decline to specify

Arab or Middle Eastern: Please check the box next to one of the following that best describes your ethnicity.

- ☐ Arab or Middle Eastern
- ☐ Not Arab or Middle Eastern
- ☐ Unknown or Decline to specify

Do you have symptoms related to COVID-19? ☐ Yes ☐ No ☐ Unknown
If yes, what is the date the symptoms started? _____

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First Name: _____ Last Name: _____
DOB: _____
School: _____

Please carefully read the following informed consent:

Please carefully read the following notice and sign the authorization to test for COVID-19.

1. I understand that the COVID-19 testing will be conducted through a BinaxNOW antigen test, or other acceptable test as ordered by an authorized medical provider or a public health official.
2. I understand that my ability to receive testing is limited to the availability of test supplies.
3. I understand that I am not creating a patient relationship with the ordering physician by participating in this testing. I understand the entity performing the test is not acting as my medical provider. Testing does not replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results and my medical care. I agree I will seek medical advice, care, and treatment from my medical provider or other health care entity if I have questions or concerns, if I develop symptoms of COVID-19, or if my condition worsens.
4. I understand it is my responsibility to inform my health care provider of a positive test result, and that a copy will not be sent to my health care provider for me.
5. I understand that my antigen test result will be available in 15-30 minutes. If the result is positive, it will need to be confirmed with a PCR test.
6. I understand and acknowledge that a positive antigen test result is an indication that I need to self-isolate to avoid infecting others until I obtain a negative PCR test result.
7. I have been informed of the test purpose, procedures, and potential risks and benefits. I will have the opportunity to ask questions before proceeding with a COVID-19 diagnostic test at the testing site. I understand that if I do not wish to continue with the COVID-19 diagnostic test, I may decline to test.
8. I understand that to ensure public health and safety and to control the spread of COVID-19, my test results may be shared without my individual authorization.
9. I understand that my test results will be disclosed to the appropriate public health authorities as required by law.
10. I understand that I may withdraw my consent to participate in testing at any time.

AUTHORIZATION/CONSENT TO TEST FOR COVID-19

☐ I agree to undergo the COVID-19 antigen testing for the duration of the testing period.

_____ _____

Patient/Parent/Legal Guardian Signature Date