Consent and Registration Form for Rapid COVID-19 Antigen Test

Testing Facility: NEW LOTHROP PUBLIC SCHOOLS
Address: 9285 EASTON RD., NEW LOTHROP, MI 48460

Phone: 810-638-5091 Organization: PUBLIC SCHOOL

Testing Date: _____

Personal Information
First Name: _____ Last Name: _____ Grade: _____

DOB: (mm/dd/yyyy) ____ /____ / _____

Consent and Registration Form for Rapid COVID-19 Antigen Test

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 understand that my test results will be disclosed to the appropriate public health authorities as required by law.

AUTHORIZATION/CONSENT TO TEST FOR COVID-19

☐ I agree to undergo the COVID-19 antigen testing for the duration of the testing period/ authorize my child to undergo testing

_____ _____

Patient/Parent/Legal Guardian Signature Date