☐ **Symptomatic Test** ☐ **Asymptomatic Test**

Park Hill School District

Consent For COVID-19 Antigen Testing

Voluntary Testing Consent & Acknowledgement Form for Park Hill School District

Enclosed with this form is a notice entitled "School Reporting of a Positive or Suspected COVID-19 Student or Employee." If that notice is not enclosed, it can be located at the following hyperlink:
https://health.mo.gov/living/healthcondiseases/communicable/novel-coronavirus/pdf/school-covid-reporting.pdf

BinaxNOW is an antigen test that detects the presence of the SARS-CoV-2, which is the virus that causes a COVID-19 infection, in about fifteen (15) minutes. The specimen for the test is collected via nasal swab. This test is completely voluntary and will not be administered unless this form is signed. As stated in the above notice, a positive result of this test will be immediately reported to the Local Public Health Agency ("LPHA") so that it can begin contact tracing and instituting appropriate disease control measures. The LPHA solely manages these efforts. Additionally, all test results will be shared with the Department of Health and Senior Services pursuant to state regulation.

BinaxNOW may be administered to individuals suffering from symptoms consistent with an infection of COVID-19 or asymptomatic individuals with a known exposure. A negative test result may indicate that symptoms present are more likely the result of a common cold, allergies, or a different illness. If symptoms consistent with an infection of COVID-19 develop or persist after a negative test result, consult with a health care provider or the appropriate LPHA to determine the best course of action.

Test results and testing information will be kept confidential by Park Hill School District, the LPHA, and Department of Health and Senior Services.

By completing and signing this form, you voluntarily consent to the test being performed on the named individual, and you acknowledge that you have read and understand the above statements and the notice entitled "School Reporting of a Positive or Suspected COVID-19 Student or Employee."

*****Testing by appointment only—call your school nurse to schedule an appointment at the Park Hill Antigen Test Site*****

CONSENT & ACKNOWLEDGMENT

Student Name:	**Student DOB:**	**Gender:** ☐ Male ☐ Female ☐ Other
Address:	**Phone:**	
Race: ☐Asian ☐Black/African American ☐White/Caucasian ☐Native Hawaiian/Other ☐American Indian/Alaskan Native ☐Other/Refused/Unknown	**Ethnicity:** ☐Hispanic ☐Non-Hispanic ☐Unknown	**School:**

Check any symptoms present:

☐ **Fever or chills**	☐ **Fatigue**	☐ **New loss of taste/smell**	☐ **Nausea/Vomiting**
☐ **Cough**	☐ **Muscle/body aches**	☐ **Sore throat**	☐ **Diarrhea**
☐ **Shortness of breath/difficulty breathing**	☐ **Headache**	☐ **Congestion/runny nose**	

Date symptoms began: _____

Guardian Name (Please Print):	**Guardian Signature:**

For District Use:

Received by:	**Date:**	**Time:**

Results: ☐ **Negative** ☐ **Positive** ☐ **Inconclusive**