



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.

Except as required by law, 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

Employee Name:	Employee DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Address:	Phone:	
Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Native Hawaiian/Other <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other/Refused/Unknown	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	Building Worksite:
Check any symptoms present:		
<input type="checkbox"/> Fever or chills	<input type="checkbox"/> Fatigue	<input type="checkbox"/> New loss of taste/smell
<input type="checkbox"/> Cough	<input type="checkbox"/> Muscle/body aches	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Shortness of breath/difficulty breathing	<input type="checkbox"/> Headache	<input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Diarrhea
Date symptoms began: _____		
Name (Please Print):	Signature:	
For District Use:		
Received by:	Date:	Time:
Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Inconclusive		