USD 373 CONSENT FOR COVID-19 TEST

I authorize USD 373 to administer

_____ Abbott BinaxNOW COVID-19 Ag testing (antigen test)

and/or

_____ Accula Rapid PCR nasal swab test

to potentially detect Covid-19 for (name): _____. I understand that this testing is voluntary.

I authorize my test results to be disclosed to USD 373, the Harvey County Health Department, and the Kansas Department of Health and Environment and understand that such disclosure will also be made consistent with applicable law.

I acknowledge that a positive test result is an indication that I must abide by USD 373's exclusion policies and all applicable federal, state and/or local guidance on isolation and quarantine to avoid infecting others.

I understand that by signing this document and agreeing to undergo Covid-19 testing that I am not creating a patient relationship with USD 373. I understand that USD 373 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. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.

I understand that, as with any medical test, there is the potential for false positive or false negative test results to occur.

I, the undersigned, do hereby consent to being tested for the presence of SARS-CoV-2. I consent to this testing freely and voluntarily.

Printed Name: _____

Signature: _____

☐ Verbal permission given via phone (Nurse initials) _____ DATE: _____

Relationship: _____ Date: _____ D.O.B. _____

Parent DOB is needed for the State lab. They will not accept a requisition on a minor without the parent DOB.