# Boyle County Schools Health Services

## *Informed Consent for Coronavirus (COVID-19) Screening*

I authorize Boyle County Schools Health Services staff and/or its contracted lab to conduct collection, testing, and screening for COVID-19 through a [nasopharyngeal swab]. I acknowledge that this screening is being conducted at the request of Boyle County Schools and any results or findings are for its benefit in order to determine whether it is safe for me to return to school or work. I further acknowledge and expressly consent to each of the following:

(1) I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.

(2) I acknowledge that a positive test result is an indication that I must self-isolate in an effort to avoid infecting others.

(3) I understand that I am not creating a patient relationship with Boyle County Schools Health Services and/or its contracted lab by participating in this screening. I further understand that Boyle County Schools Health Services and/or its contracted lab is not acting as my medical provider and is not conducting a diagnostic test.

(4) I understand that 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 that I will seek medical advice, diagnosis, care, and any necessary treatment from a medical provider if I have questions or concerns, or if my condition requires me to do so. If I do not have a medical provider, I may ask Boyle County Schools Health Services and/or its contracted lab for a list of health care professionals from whom I may receive follow-up care.

(5) I understand that, as with any medical test, there is the potential for the occurrence of a false positive or false negative test result.

(6) I understand that I can revoke this Consent for further testing by sending a written notice to the school nurse.

I have been given the opportunity to ask questions about this Consent before I sign, and I have been told that I can ask other questions at any time.

Patient Name (please print):_____Date of birth:_____

Parent/Guardian Signature:_____

Phone #:_____Email:_____

Address:_____