Consent Form for Rapid Antigen Test for COVID-19 and Flu A+B

Student Name:
Student Birthdate:
School:
Parent/Guardian Name(s):
Home Address:
Phone Number:

Please carefully read the following informed consent notice and sign the authorization to test for COVID-19.

1. I understand that COVID-19 and flu A+B testing of the above-named student will be conducted through an BD Veritor Rapid Antigen Test provided by the Washington State Department of Health and acknowledge that the fact sheet for the test has been made available to me.
2. I understand that the ability of the above-named student to receive testing is limited to the availability of test supplies.
3. I understand the entity performing the test is not acting as the above-named student's medical provider. Testing does not replace treatment by a medical provider. I assume complete and full responsibility to take appropriate action with regards to the test results, including seeking medical advice, care, and treatment from a medical provider or other health care entity if I have questions or concerns, if the above-named student develops symptoms of COVID-19 and flu A+B, or if the above-named student's condition worsens.
4. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 and flu A+B test result.
5. I understand it is my responsibility to inform the above-named student's health care provider of a positive test result, and that a copy will not be sent to the above-named student's health care provider for me.
6. I understand that the antigen test result will be available in 15-30 minutes.
7. I understand and acknowledge that a positive antigen test result is an indication that the above-named student needs to self-isolate to avoid infecting others.
8. I have been informed of the test purpose, procedures, and potential risks and benefits. I will have the opportunity to ask questions before proceeding with a COVID-19 and flu A+B test. I understand that if I do not wish for the above-named student to continue with the COVID-19 and flu A+B diagnostic test, I may decline the test.
9. I understand that to ensure public health and safety and to control the spread of COVID-19 and flu, the test results may be shared without my individual authorization.
10. I understand that the test results will be disclosed to the appropriate public health authorities as required by law.
11. I understand that I may withdraw my consent to the testing at any time before it is performed.

AUTHORIZATION/CONSENT TO TEST FOR COVID-19 and flu A+B

□ I consent to authorize the above-named student to undergo COVID-19 and flu A+B testing.

_____ _____

Parent/Guardian Signature Date

□ I consent to undergo COVID-19 and flu A+B testing.

_____ _____

Student (18 or older) Signature Date