

Consent and Registration Form for Rapid COVID-19 Antigen Test

First Name: _____ Last Name: _____

DOB: _____

School: _____

Please carefully read the following informed consent:

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

1. I understand that the COVID-19 testing will be conducted through a BinaxNOW antigen test, or other acceptable test as ordered by an authorized medical provider or a public health official.
2. I understand that my ability to receive testing is limited to the availability of test supplies.
3. I understand that I am not creating a patient relationship with the ordering physician by participating in this testing. I understand the entity performing the test 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 and my medical care. I agree I will seek medical advice, care, and treatment from my medical provider or other health care entity if I have questions or concerns, if I develop symptoms of COVID-19, or if my condition worsens.
4. I understand it is my responsibility to inform my health care provider of a positive test result, and that a copy will not be sent to my health care provider for me.
5. I understand that my antigen test result will be available in 15-30 minutes. If the result is positive, it will need to be confirmed with a PCR test.
6. I understand and acknowledge that a positive antigen test result is an indication that I need to self-isolate to avoid infecting others until I obtain a negative PCR test result.
7. 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 diagnostic test at the testing site. I understand that if I do not wish to continue with the COVID-19 diagnostic test, I may decline to test. If I decline to test, I may not participate in athletic practice or competition.
8. I understand that to ensure public health and safety and to control the spread of COVID-19, my test results may be shared without my individual authorization.
9. I understand that my test results will be disclosed to the appropriate public health authorities as required by law.
10. I understand that I may withdraw my consent to participate in testing at any time, and that doing so will forfeit my right to participate in the MI Safer Sports program.

AUTHORIZATION/CONSENT TO TEST FOR COVID-19

- I agree to undergo the COVID-19 antigen testing for the duration of the testing period/ authorize my child to undergo testing

Patient/Parent/Legal Guardian Signature

Date

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Testing Facility: **Lowell High School**

Address: **11700 Vergennes, Lowell MI 49331**

Phone: **616-987-2902**

Organization: **Lowell High School**

Testing Date: _____

Personal Information

First Name: _____ Last Name: _____ Middle: _____

Phone Number: () - _____ - _____ Email Address: _____

DOB: (mm/dd/yyyy) ____ / ____ / _____ Biological Sex: * Male * Female * Prefer not to answer

Street Address: _____

City/State/Zip: _____

Race: Please check the box next to the one that best describes your race.

- American Indian/Alaskan Native
- Black/African American
- Asian
- White/Caucasian
- Hawaiian/ Pacific Islander
- Other
- Unknown

Hispanic or Latino: Please check the box next to one of the following that best describes your ethnicity.

- Latino or Hispanic
- Not Latino or Hispanic
- Unknown or Decline to specify

Arab or Middle Eastern: Please check the box next to one of the following that best describes your ethnicity.

- Arab or Middle Eastern
- Not Arab or Middle Eastern
- Unknown or Decline to specify

Do you have symptoms related to COVID-19? Yes No Unknown

If yes, what is the date the symptoms started? _____