Consent Form for Rapid COVID-19 Antigen Testing

Name:
Birthdate:
School:
Parent/Guardian Name(s) if applicable printed:
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 testing of the above named person will be conducted through an Abbott Laboratories via BinaxNOW antigen test provided by GFW School District and acknowledge that testing and a BinaxNOW Fact Sheet will be made available to me.
2. I understand the entity performing the test is not acting as the above named person's medical provider. Testing does not replace treatment by a medical professional. 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 healthcare entity if I have questions or concerns., if the above named person develops symptoms of COVID-19, or if the above named person's condition worsens
3. I understand that, as with any medical test, there is a potential for a false positive or false negative COVID-19 test result.
4. I understand it is my responsibility to inform the above-named person's healthcare provider of a positive test result, and that a copy will not be sent to the above-named person's healthcare provider for me.
5. I understand that the antigen test result will be available within 15-30 minutes.
6. I understand and acknowledge that a positive antigen test result is an indication that the above-named person needs to self-isolate to avoid infecting others.
7. I have been informed of the test purpose, procedures, and potential risks and benefits. I will have the above-named person to continue with a diagnostic COVID-19 test, I may decline the antigen test.
8. I understand that the test results, whether positive or negative, will be disclosed to the appropriate public health authorities (Minnesota Department of Health via Casetivity)
9. I understand that it is my responsibility to inform my employer or school of any positive test results.
10. I understand that I may withdraw my consent to the testing at any time before it is performed.
11. I understand this is consent for this continued COVID-19 testing at GFW during the 2021-2022 school year.

*** *Please see next page for signature lines* ***

Authorization/Consent to test for COVID-19

_____ (initial) I consent to authorize the above-named person to undergo COVID-19 testing.

_____ _____

Parent/Guardian Signature Date

_____ (initial) I consent to undergo COVID-19 testing

_____ _____

Signature of above-named person being tested(if applicable) Date