Consent Form for Rapid COVID-19 Antigen Test

Name:
Birthdate:
School:
Parent/Guardian Name(s) [if applicable]:
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 a rapid antigen test provided by the Washington State Department of Health. The test provided will be either Abbott Laboratory's BinaxNOW or AccessBio's CareStart. I acknowledge that the *BinaxNOW Fact Sheet for Patients* and *CareStart Fact Sheet for Patients* has been made available to me.
2. I understand that the ability of the above-named person 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 person'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 person develops symptoms of COVID-19, or if the above-named person'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 test result.
5. I understand it is my responsibility to inform the above-named person's health care provider of a positive test result, and that a copy will not be sent to the above-named person'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 person 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 test. I understand that if I do not wish for the above-named person to continue with the COVID-19 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, 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, the Office of Superintendent of Public Instruction, and as otherwise permitted or 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

□ I consent to authorize the above-named person to undergo COVID-19 testing.

_____ _____

Parent/Guardian Signature Date

□ I consent to undergo COVID-19 testing.

_____ _____