



# Consent Form for Rapid COVID-19 Antigen Test

Student Name \_\_\_\_\_

Student Birthday \_\_\_\_\_

Phone Number \_\_\_\_\_ School \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

Home Address \_\_\_\_\_

**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 an Abbott Laboratories BinaxNOW antigen test provided by the Washington State Department of Health.
2. I understand that my ability to receive testing is limited to the availability of test supplies.
3. 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 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 my health care provider of a positive test result, and that a copy will not be sent to my health care provider for me.
6. 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, which I am responsible for obtaining.
7. 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.
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 to continue with the COVID-19 diagnostic test, I may decline to test.
9. 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.
10. I understand that my 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 participate in testing at any time.

**AUTHORIZATION/CONSENT TO TEST FOR COVID-19**

- ☐ I agree to authorize my child to undergo COVID-19 testing.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

- ☐ I agree to undergo COVID-19 testing.

\_\_\_\_\_  
Student (18 or older) Signature

\_\_\_\_\_  
Date