

Consent for BinaxNow or PCR COVID-19 Testing at MCPS Adult (Staff/Visitor)

Full Name of Individual Being Tested		Birth Sex (mark one) Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer <input type="checkbox"/>	
Street Address <input type="checkbox"/> Group Home		City	State
Date of Birth (mm/dd/yyyy)		Phone #	
NOT REQUIRED (but may determine recommendations to stay home or not) Date of Covid Vaccine shot? _____ Booster date: _____ Not vaccinated for COVID-19 <input type="checkbox"/>	Race (optional): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Prefer not answer Tribal affiliation: _____ Are you Hispanic or Latino (optional): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer		
Email address Click or tap here to enter text.			
TEST 1			
No Symptoms: <input type="checkbox"/> Identified as a Close Contact <input type="checkbox"/> School/buildings work/attended since symptom onset: _____ Symptom Onset Date: _____ Symptom type: <input type="checkbox"/> Fever 100.4+ <input type="checkbox"/> Feeling feverish <input type="checkbox"/> Chills <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Fatigue <input type="checkbox"/> Muscle or body aches <input type="checkbox"/> Headache <input type="checkbox"/> New loss of taste <input type="checkbox"/> New loss of smell <input type="checkbox"/> Sore throat <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Runny nose <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting			
<hr/>			
For MCPS Use			
Result Negative Positive	Neg Pos	Date of test	Notified of result
BinaxNow <input type="checkbox"/>	PCR/NAT <input type="checkbox"/>	_____	<input type="checkbox"/> _____
Staff conducting test: _____			
TEST 2			
No Symptoms: <input type="checkbox"/> Identified as a Close Contact <input type="checkbox"/> School/buildings work/attended since symptom onset: _____ Symptom Onset Date: _____ Symptom type: <input type="checkbox"/> Fever 100.4+ <input type="checkbox"/> Feeling feverish <input type="checkbox"/> Chills <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Fatigue <input type="checkbox"/> Muscle or body aches <input type="checkbox"/> Headache <input type="checkbox"/> New loss of taste <input type="checkbox"/> New loss of smell <input type="checkbox"/> Sore throat <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Runny nose <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting			
<hr/>			
For MCPS Use			
Result Negative Positive	Neg Pos	Date of test	Notified of result
BinaxNow <input type="checkbox"/>	PCR/NAT <input type="checkbox"/>	_____	<input type="checkbox"/> _____
Staff conducting test: _____			
TEST 3			
No Symptoms: <input type="checkbox"/> Identified as a Close Contact <input type="checkbox"/> School/buildings work/attended since symptom onset: _____ Symptom Onset Date: _____ Symptom type: <input type="checkbox"/> Fever 100.4+ <input type="checkbox"/> Feeling feverish <input type="checkbox"/> Chills <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Fatigue <input type="checkbox"/> Muscle or body aches <input type="checkbox"/> Headache <input type="checkbox"/> New loss of taste <input type="checkbox"/> New loss of smell <input type="checkbox"/> Sore throat <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Runny nose <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting			
<hr/>			
For MCPS Use			
Result Negative Positive	Neg Pos	Date of test	Notified of result
BinaxNow <input type="checkbox"/>	PCR/NAT <input type="checkbox"/>	_____	<input type="checkbox"/> _____
Staff conducting test: _____			

PLEASE SEE REVERSE SIDE FOR SIGNATURE

CONSENT FOR TESTING (Adult)

1. I am the individual seeking BinaxNOW COVID-19 Ag Card and/or PCR testing.
2. I authorize MCPS to conduct BinaxNOW COVID-19 and/or PCR testing on me.
3. I understand that processing the BinaxNOW COVID-19 specimen results takes 15 minutes and PCR result availability will depend entirely on state lab turnaround times and may be delayed.
4. I understand that MCPS will release the results of my test if positive to the health department, and a physician or healthcare provider if I so designate.
5. I understand my test results will be disclosed to county and state health entities as required by law.
6. I acknowledge that a positive test result is an indication that I may be required to isolate to avoid infecting others. Should the test result be positive, I understand I will be contacted by local public health personnel with further instruction.
7. I understand that a patient relationship with MCPS is not created by my participation in testing. I understand MCPS personnel administering the testing are not acting as my medical provider.
8. I understand testing does not replace treatment by a medical provider. I will take appropriate action with regards to any test results I receive. I will seek medical advice, care and treatment from my medical provider if my condition worsens.
9. I hereby knowingly and voluntarily consent to have my sample taken and analyzed and I hereby waive any and all rights, claims, or causes of action of any kind for myself, my heirs, executors, administrators, assigns, or personal representatives, and I hereby release MCPS and its agents for any injury that I may suffer as a direct or indirect result of participation in this testing activity.
10. I confirm that I currently have one or more symptoms consistent with COVID-19, as described by the Centers for Disease Control as of the date of this test and that I have not had symptoms for more than 7 days or am a close contact or am a close contact or being tested for screening testing.
11. I understand that the BinaxNow rapid test is an antigen test and is not 100% effective at detecting all positive cases of COVID-19 and may produce a false negative result and that a followup PCR test may be recommended.
12. I understand that if my test is negative, I may be advised to seek the advice of a healthcare provider to evaluate symptoms. I also understand that I may need a PCR test and that I cannot return to work until I have been free of fever (without the use of fever-reducing agents) for at least 24 hours and until symptoms are improving, or as otherwise advised by my healthcare provider.
13. I understand that this test is not yet approved or cleared by the United States FDA. When there are no FDA-approved or cleared tests available, and other criteria are met, the FDA can make tests available under an emergency access mechanism called an Emergency Use Authorization (EUA).
14. I acknowledge that I have received a copy of the “Fact Sheet for Patients” provided by Abbott, the manufacturer of the test kit, and that I understand its content, having had all of my questions answered.

Consent valid for 2022-2023 school year, unless revoked in writing.

Signature of Test Recipient

Date

Receipt of test results:

Telephone Text

Email