Consent for BinaxNow COVID-19 Rapid Testing at MCPS (Student or Minor)

Full Name of Individual Being Tested			Sex (circle) Male Female
Street Address	City	State	Zip
Date of Birth (mm/dd/yy)	Name of Parent or Guardian (Printed)		
Parent or Guardian Phone Number	Parent or Guardian Email		
For MCPS Use **Result** Negative Positive Parent or Guardian Notified ☐	Name of MCPS Staff Conducting Test		

1. I am the parent or legal guardian seeking BinaxNOW COVID-19 Ag Card testing for my child.

2. I authorize MCPS to conduct BinaxNOW COVID-19 testing on my child currently or if he or she displays symptoms consistent with COVID-19 while at school or a school activity and meets the criteria for testing. I understand that MCPS will conduct the BinaxNOW COVID-19 testing at no additional cost to me or my child.

3. I understand and acknowledge that testing is voluntary; however, MCPS reserves the right to direct my child leave school property (either through a parent pick-up or through the child transporting him/herself) in the event he/she is displaying possible COVID-19 symptoms regardless of whether I agree to BianaxNOW COVID-19 testing for my child.

4. I understand that if staffing or supplies are not available for testing at MCPS, BinaxNow Rapid Testing will not be available and I will seek testing elsewhere, if needed. I understand and acknowledge that any further testing would not be completed at the expense of MCPS.

5. I understand that processing the BianaxNOW COVID-19 specimen results takes 15 minutes and if a PCR swab is performed elsewhere, the results of that test will depend entirely on state lab turnaround times.

6. I understand that MCPS will release the results of my child's test **if positive** to the health department and a physician or healthcare provider if I so designate.

7. I understand the test results will be disclosed to county and state health entities as required by law.

8. I acknowledge that a positive test result is an indication that my child will 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.

9. I understand that a patient relationship with MCPS is not created by my child's participation in testing. I understand MCPS personnel administering the testing are not acting as my child's medical provider. I understand and acknowledge that the foregoing description of risks and limitations is incomplete, and these risks and limitations and other unlisted, unknown, or unanticipated risks and limitations may result in injury or damage.

10. I understand testing does not replace treatment by a medical provider. I will take appropriate action with regards to any test results my child receives. I will seek medical advice, care and treatment from my child's medical provider if his or her condition worsens.

11. I hereby knowingly and voluntarily consent to have my child's sample taken by swabbing the nose (anterior/midturbinate nasal swab) 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 those of my child and I hereby release MCPS and its agents for any injury that my child may suffer as a direct or indirect result of participation in this testing activity.

12. I confirm that my child will only be tested if he or she has one or more symptoms consistent with COVID-19 as described by the Centers for Disease Control for 7 days or less, as of the date of the test.

13. I understand that this is an antigen test and is not 100% effective at detecting all positive cases of COVID-19 and may produce a false negative result.

14. I understand that if my child's test is negative, I may be advised to seek the advice of a healthcare provider to evaluate symptoms for him or her. I also understand that my child may need a PCR test and cannot return to school until he or she has 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 and health department.

15. 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). I understand that this test has been granted emergency use authorization.

16. 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.

17. I understand that I may withdraw this consent at any time prior to a test or, if a test or tests have already been conducted, prior to a subsequent test being conducted and must do so in writing.

_____ _____
Signature of Parent or Guardian of Test Recipient **Date**

_____ _____
Signature of Student if 18 years of age or over **Date**

OR

_____ _____
☐Telephone ☐ Email Consent Obtained From Above Parent or Guardian (If email, print and attach) **Date**

_____ _____
MCPS Witness to Phone or Email Consent **Date**

Has your child had a recent exposure (in the last 2 weeks) to someone who had COVID-19 (Even if not considered a close contact)?_____

Date symptoms began_____

❑ Cough ☐ Chills ☐ Sore throat ☐ Runny nose/congestion ☐ Nausea ☐ Diarrhea
❑ Shortness of breath or trouble breathing ☐ New loss of taste and/or smell ☐ Vomiting
❑ Fever ☐ Body aches and pains ☐ Headache ☐ Fatigue