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

Full Name of Individual Being Tested			**Birth Sex (mark one)** Female☐ Male☐ Other ☐ Prefer not to answer☐
Street Address ☐ **Group Home**	**City**	**State**	**Zip**

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 ☐	**Race (optional): ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/other Pacific Islander ☐White ☐Other ☐Prefer not answer** **Tribal affiliation:**_____ **Are you Hispanic or Latino (optional):** **☐Yes ☐No ☐Prefer not to answer**

Email address
Click or tap here to enter text.

TEST 1

No Symptoms: ☐ Identified as a Close Contact ☐ **School/buildings work/attended since symptom onset:**_____
Symptom Onset Date:_____
Symptom type:
☐ Fever 100.4+ ☐ Feeling feverish ☐ Chills ☐ Cough ☐ Shortness of breath ☐ Difficulty breathing ☐ Fatigue
☐ Muscle or body aches ☐ Headache ☐ New loss of taste ☐ New loss of smell ☐ Sore throat ☐ Nasal congestion
☐ Runny nose ☐ Nausea ☐ Diarrhea ☐ Vomiting

For MCPS Use Date of test Notified of result
Result Negative Positive Neg Pos _____ ☐ _____
BinaxNow ☐ PCR/NAT ☐
Staff conducting test:_____

TEST 2

No Symptoms: ☐ Identified as a Close Contact ☐ **School/buildings work/attended since symptom onset:**_____
Symptom Onset Date:_____
Symptom type:
☐ Fever 100.4+ ☐ Feeling feverish ☐ Chills ☐ Cough ☐ Shortness of breath ☐ Difficulty breathing ☐ Fatigue
☐ Muscle or body aches ☐ Headache ☐ New loss of taste ☐ New loss of smell ☐ Sore throat ☐ Nasal congestion
☐ Runny nose ☐ Nausea ☐ Diarrhea ☐ Vomiting

For MCPS Use Date of test Notified of result
Result Negative Positive Neg Pos _____ ☐ _____
BinaxNow ☐ PCR/NAT ☐
Staff conducting test:_____

TEST 3

No Symptoms: ☐ Identified as a Close Contact ☐ **School/buildings work/attended since symptom onset:**_____
Symptom Onset Date:_____
Symptom type:
☐ Fever 100.4+ ☐ Feeling feverish ☐ Chills ☐ Cough ☐ Shortness of breath ☐ Difficulty breathing ☐ Fatigue
☐ Muscle or body aches ☐ Headache ☐ New loss of taste ☐ New loss of smell ☐ Sore throat ☐ Nasal congestion
☐ Runny nose ☐ Nausea ☐ Diarrhea ☐ Vomiting

For MCPS Use Date of test Notified of result
Result Negative Positive Neg Pos _____ ☐ _____
BinaxNow ☐ PCR/NAT ☐
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 BianaxNOW 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 2023-2024 school year, unless revoked in writing.

_____ _____

Signature of Test Recipient **Date**

Receipt of test results:

☐ **Telephone** ☐ **Text**

☐ **Email**