Consent for BinaxNow or PCR COVID-19 Testing at MCPS Minor (Student/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:

SCHOOL:

TEST 1

No Symptoms: ☐ Identified as a Close Contact ☐

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 ☐

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 ☐

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 (Minor/Student)

1. I am the parent or legal guardian seeking BinaxNOW COVID-19 Ag Card and/or PCR testing for my child.
2. I authorize MCPS to conduct PCR and/or 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 or is undergoing asymptomatic surveillance 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, if applicable) in the event he/she is displaying possible COVID-19 symptoms regardless of whether I agree to PCR and/or BianaxNOW COVID-19 testing for my child.
4. I understand that if staffing or supplies are not available for testing at MCPS, PCR and 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 at MCPS or elsewhere, the results of that test will depend entirely on local or 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. All positive and negative results are reported to the state as required by law.
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 or is undergoing surveillance testing or is a close contact to a positive case.
13. I understand that BinaxNow 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.

Consent valid for 2023-2024 school year, unless revoked in writing.

Print Name of Parent or Guardian of Test Recipient OR Student if 18 years of age or older	**Signature**	**Date**

Signature of MCPS Employee Obtaining Consent **	**Date**

*****Consent obtained must be from Legal Guardian of Minor with corresponding phone number and/or email as listed in Infinite Campus***

Print Name of Witness to Verbal Consent***	**Signature**	**Date**

******Witness must be MCPS employee or agreeing adult (not student)***

Receipt of test results:

☐ **Telephone** ☐ **Text**

☐ **Email**