

# Consent Form for Rapid COVID-19 Antigen Test

Name:
Birthdate:
School:
Parent/Guardian Name(s) [if applicable]:
Home Address:
Phone Number:

**Please carefully read the following informed consent notice and sign the authorization to test for COVID-19.**

1. I understand that COVID-19 testing of the above-named person will be conducted through a BD Laboratories Veritor antigen test, AccessBio Laboratories CareStart antigen test, or Abbott Laboratories BinaxNOW antigen test provided by the Washington State Department of Health and acknowledge that the Veritor Plus, CareStart, BinaxNOW Fact Sheets for Patients for the test have been made available to me. I understand that the ability of the above-named person to receive testing is limited to the availability of test supplies.
2. I understand the entity performing the test is not acting as the above-named person's medical provider. Testing does not replace treatment by a medical provider. I assume complete and full responsibility to take appropriate action with regards to the test results, including seeking medical advice, care, and treatment from a medical provider or other health care entity if I have questions or concerns, if the above-named person develops symptoms of COVID-19, or if the above-named person's condition worsens.
3. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.
4. I understand it is my responsibility to inform the above-named person's health care provider of a positive test result, and that a copy will not be sent to the above-named person's health care provider for me.
5. I understand that the antigen test result will be available in 15-30 minutes.
6. I understand and acknowledge that a positive antigen test result is an indication that the above-named person needs to self-isolate to avoid infecting others.
7. 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 for the above-named person to continue with the COVID-19 diagnostic test, I may decline the test.
8. I understand that to ensure public health and safety and to control the spread of COVID-19, the test results may be shared without my individual authorization.
9. I understand that the test results will be disclosed to the appropriate public health authorities, the Office of Superintendent of Public Instruction, and as otherwise permitted or required by law.
10. I understand that I may withdraw my consent to the testing at any time before it is performed.

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

- I consent to authorize the above-named person to undergo COVID-19 testing.

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

\_\_\_\_\_  
Date

- I consent to undergo COVID-19 testing.
- \_\_\_\_\_