

# Consent Form for Rapid Antigen Test for COVID-19 and Flu A+B

Student Name:
Student Birthdate:
School:
Parent/Guardian Name(s):
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 and flu A+B testing of the above-named student will be conducted through a BD Veritor System provided by the Washington State Department of Health.
2. I understand that the ability of the above-named student to receive testing is limited to the availability of test supplies.
3. I understand the entity performing the test is not acting as the above-named student'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 student develops symptoms of COVID-19 and flu A+B, or if the above-named student's condition worsens.
4. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 and flu A+B test result.
5. I understand it is my responsibility to inform the above-named student's health care provider of a positive test result, and that a copy will not be sent to the above-named student's health care provider for me.
6. I understand that the antigen test result will be available in 15-30 minutes.
7. I understand and acknowledge that a positive antigen test result is an indication that the above-named student needs to self-isolate to avoid infecting others.
8. 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 and flu A+B test. I understand that if I do not wish for the above-named student to continue with the COVID-19 and flu A+B diagnostic test, I may decline the test.
9. I understand that to ensure public health and safety and to control the spread of COVID-19 and flu, the test results may be shared without my individual authorization.
10. I understand that the test results will be disclosed to the appropriate public health authorities as required by law.
11. 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 and flu A+B**

- I consent to authorize the above-named student to undergo COVID-19 and flu A+B testing.

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

\_\_\_\_\_  
Date

- I consent to undergo COVID-19 and flu A+B testing.

\_\_\_\_\_  
Student (18 or older) Signature

\_\_\_\_\_  
Date