**Consent and Registration Form for Rapid COVID-19 Antigen Test**

Testing Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Testing Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID#:

**Personal Information**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: ( ) - \_\_\_\_\_\_ - \_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: (mm/dd/yyyy) \_\_\_\_ /\_\_\_\_ / \_\_\_\_\_\_\_ Biological Sex: \* Male \* Female \* Prefer not to answer

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race: Please check the box next to the one that best describes your race.**

* American Indian/Alaskan Native
* Black/African American
* Asian
* White/Caucasian
* Hawaiian/ Pacific Islander
* Other
* Unknown

**Hispanic or Latino: Please check the box next to one of the following that best describes your ethnicity.**

* Latino or Hispanic
* Not Latino or Hispanic
* Unknown or Decline to specify

**Arab or Middle Eastern: Please check the box next to one of the following that best describes your ethnicity.**

* Arab or Middle Eastern
* Not Arab or Middle Eastern
* Unknown or Decline to specify

Do you have symptoms related to COVID-19? c Yes c No c Unknown

If yes, what is the date the symptoms started? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Have your insurance information ready in case antigen test is negative and saliva PCR test is indicated. For those without insurance, no-cost test state-run test sites are available.*

**Consent and Registration Form for Rapid COVID-19 Antigen Test**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please carefully read the following informed consent:**

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

1. I understand that the COVID-19 testing will be conducted through a BinaxNOW antigen test, or other

acceptable test as ordered by an authorized medical provider or a public health official.

1. I understand that my ability to receive testing is limited to the availability of test supplies.
2. I understand that I am not creating a patient relationship with the ordering physician by participating in this

testing. I understand the entity performing the test is not acting as my medical provider. Testing does not

replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action

with regards to my test results and my medical care. I agree I will seek medical advice, care, and treatment from

my medical provider or other health care entity if I have questions or concerns, if I develop symptoms of COVID-

19, or if my condition worsens.

1. I understand it is my responsibility to inform my health care provider of a positive test result, and that a copy will not be sent to my health care provider for me.
2. I understand that my antigen test result will be available in 15-30 minutes. If the result is positive, it will need to be confirmed with a PCR test.
3. I understand and acknowledge that a positive antigen test result is an indication that I need to self-isolate to avoid infecting others until I obtain a negative PCR test result.
4. 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 diagnostic test at the testing site. I understand

that if I do not wish to continue with the COVID-19 diagnostic test, I may decline to test. If I decline to test, I may not participate in athletic practice or competition.

1. I understand that to ensure public health and safety and to control the spread of COVID-19, my test results may

be shared without my individual authorization.

1. I understand that my test results will be disclosed to the appropriate public health authorities as required by law.
2. I understand that I may withdraw my consent to participate in testing at any time, and that doing so will forfeit my right to participate in the MI Safer Sports program.

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

* I agree to undergo the COVID-19 antigen testing for the duration of the testing period/ authorize my child to undergo testing

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Parent/Legal Guardian Signature Date