Detroit Public Schools Community District is offering Rapid COVID testing for individuals who are experiencing COVID-19 like symptoms. Please complete this form and return to the school nurse.

Consent & Registration Form for Rapid COVID-19 Antigen Test

School/Worksite: _____

Testing Date: (mm/dd/yyyy) ____ /____ / _____

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

If yes, what is the date the symptoms started? (mm/dd/yyyy) ____ /____ / _____

Patient information

First Name: _____ Last Name: _____ Middle: _____

Phone Number: _____ DOB: (mm/dd/yyyy) ____ /____ / _____

Biological Sex: ☐ Male ☐ Female ☐ Prefer not to answer

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.
2. I understand that my ability to receive testing is limited to the availability of test supplies.
3. 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.
4. 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.
5. 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.
6. 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.
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 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.
8. 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.
9. I understand that my test results will be disclosed to the appropriate public health authorities as required by law.
10. I understand that I may withdraw my consent to participate in testing at any time.

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