Detroit Public Schools Community District is implementing the MDHHS Test to Stay. Test to Return. strategy that allows students/adults identified for quarantine to stay in school, provided they test with the school nurse every other day for 6 days, and remain fully masked. Please complete both sides of this form and return to the school nurse. If you do not participate in the Test to Stay or Test to Return you must remain in quarantine for the outlined number of days. Symptomatic testing will also be offered.

Consent and Registration Form for Rapid COVID-19 Antigen Test

Testing Facility: _____

Address: _____

Phone:_____ Organization: _____

Testing Date: _____

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? ☐ Yes ☐ No ☐ Unknown

If yes, what is the date the symptoms started? _____

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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.
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 as part of the “Test to Stay” initiative.

_____ _____

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Patient/Parent/Legal Guardian Signature Date