

Milan Area Schools

Consent Form for Rapid COVID-19 Antigen Test

Student First Name: _____ Student Last Name: _____

DOB: ____/____/____

School District: Milan Area Schools

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

1. I understand that the COVID-19 testing will be conducted up to three times a week through an antigen 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. 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, which will be retained by an appropriate school administrator, may be shared with third parties, including the appropriate health authorities as required by law, and I hereby consent to the same under the Family Educational Rights and Privacy Act ("FERPA") and the Health Insurance Portability and Accountability Act ("HIPAA").
9. I understand, acknowledge, assume, and accept any and all risks of injury and illness associated with participating in the testing program.
10. I understand that I may withdraw my consent to participate in testing at any time and that doing so will forfeit my ability to alter quarantine requirements.

AUTHORIZATION/CONSENT TO TEST FOR COVID-19

- I agree to undergo (or authorize my student to undergo) COVID-19 antigen testing during the 2021-2022 school year as required under quarantine guidelines.

Patient/Parent/Legal Guardian Signature

Date